

Family Planning Program Policy Manual



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Health and Human
Services

Family Planning Program Policy Manual

Health and Human Services Commission

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PROGRAM AUTHORIZATION AND SERVICES

Purpose of Program

The purpose of the Health and Human Services Commission (HHSC) Family Planning Program (FPP) is to provide comprehensive family planning services to reduce unintended pregnancies, positively affect future pregnancies, and improve the health status of women and men.

Program Background

HHSC Family Planning Program – A statewide program that provides family planning and related health services to low-income women and men.

Title XIX – Medicaid (Title XIX of the Social Security Act) was created by Congress in 1965. All agencies that receive HHSC FPP funding are required to be enrolled providers of services to Medicaid-eligible women and men. (Federal regulation citation: Title XIX, Social Security Act, [42 USC § 1396-1396v et. seq.] Grants to States for Medical Assistance Programs).

Funding Sources – FPP services are funded by State General Revenue and federal TANF to XX funds.

Rules - The state rules that apply most specifically to Family Planning Program services in Texas are found in the [Texas Administrative Code \(TAC\), Title 1, Part 15, Chapter 382, Subchapter B.](#)

Purpose of the Manual

The *HHSC Family Planning Program Policy Manual* is a guide for contractors who deliver HHSC FPP services in Texas. FPP providers must also follow policies and procedures as established by the Texas Medicaid Program in the Texas Medicaid Provider Procedures Manual (TMPPM).

Federal and state laws related to reporting of child abuse, operation of health facilities, professional practice, insurance coverage, and similar topics also impact family planning services. Contractors are required to be aware of and comply with existing laws.

Family planning contractors also must be in compliance with the [DSHS Standards for Public Health Clinic Services](#). For additional information about HHSC FPP services, access the [HHSC Family Planning Program website](#).

Definitions

The following words and terms, when used in this manual, have the following meanings:

Class D Pharmacy License – A pharmacy license issued to a pharmacy to dispense a limited type of drug or devices under a prescription drug order (e.g., XYZ Health Clinic). Information to apply for a Class D Pharmacy License may be found at: http://www.tsbp.state.tx.us/files_pdf/INSTRUCTIONS_CLASS_D_PHY.pdf.

Client – An individual who has been screened and been determined to be eligible for the program.

Compass 21 – TMHP's automated claims processing system used to process claims for services delivered to HHSC FPP and Medicaid.

Confidentiality – the state of keeping information private and not sharing it without permission.

Consultation – A type of service provided by a healthcare provider with expertise in a medical or surgical specialty, and who, upon request of another appropriate healthcare provider, assists with the evaluation and/or management of a patient.

Contraception – The means of pregnancy prevention, including permanent and temporary methods.

Contraceptive Method - Any birth control option approved by the United States Food and Drug Administration, with the exception of emergency contraception.

Contractor – Any entity that HHSC has contracted with to provide services. The contractor is the responsible entity even if there is a subcontractor involved who implements the services.

Co-Payment – Money collected directly from clients for services.

Cost Reimbursement – Funding used to develop and maintain contractor infrastructure for the provision of family planning services.

Elective Abortion – The intentional termination of a pregnancy by an attending physician who knows that the female is pregnant, using any means that is reasonably likely to cause the death of the fetus. The term does not include the use of any such means to terminate a pregnancy that resulted from an act of rape or incest; in a case which a female suffers from a physical disorder, physical disability,

or physical illness, including a life-endangering physical condition caused by or arising from the pregnancy, that would, as certified by a physician, place the female in danger of death or risk of substantial impairment of a major bodily function unless an abortion is performed; or in a case in which a fetus has a life-threatening physical condition that, in reasonable medical judgement, regardless of the provision of life-saving treatment, is incompatible with life outside the womb.

Eligibility Date – Date the contractor determines an individual eligible for the program; the eligibility expiration date will be twelve months after the eligibility date.

Family Planning Services – Educational or comprehensive medical services that assist women and men to plan their families, whether it is to achieve, postpone, or prevent pregnancy. If a woman chooses to become pregnant, Family Planning Services can enable the individual to determine freely the number and spacing of her children and to select the means by which this may be achieved. Services include but are not limited to: contraceptive and preconception health services (e.g., health screening for obesity, smoking, and mental health), counseling/education, pregnancy testing (if indicated), and health history, physical examinations, lab tests, STI/STD screening and services (including HIV/AIDS).

Federal Poverty Level (FPL) - The set minimum amount of income that a family needs for food, clothing, transportation, shelter and other necessities. In the United States, this level is determined by the Department of Health and Human Services. FPL varies according to family size. The number is adjusted for inflation and reported annually in the form of poverty guidelines. Public assistance programs, such as Medicaid, define eligibility income limits as some percentage of FPL.

Fee-for-Service – Payment mechanism for services that are reimbursed on a set rate per unit of service (also known as unit rate).

Fiscal Year – State fiscal year from September 1 – August 31.

Health and Human Services Commission (HHSC) – State agency with administration and oversight responsibilities for designated HHSC agencies.

Health-Care Provider - A physician, physician assistant, nurse practitioner, clinical nurse specialist, certified nurse midwife, federally qualified health center, family planning agency, health clinic, ambulatory surgical center, hospital ambulatory surgical center, laboratory, or rural health center.

Health Service Region (HSR) – Counties grouped within specified geographic service areas throughout the state.

Healthy Texas Women (HTW) – HTW is a state-funded program administered by HHSC to provide uninsured women with women’s health and family planning services such as women’s health exams, health screenings, and birth control.

Household (for the purpose of eligibility determination) – The household consists of a person living alone, or a group of two or more persons related by birth, marriage (including common law), or adoption, who reside together and are legally responsible for the support of the other person. If an unmarried applicant lives with a partner, ONLY count the partner’s income and children as part of the household group IF the applicant and his/her partner have mutual children together. Unborn children should also be included. Treat individuals who are 18 years of age as adults. No children aged 18 and older or other adults living in the home should be counted as part of the household group.

Informed Consent – The process by which a health care provider ensures that the benefits and risks of a diagnostic or treatment plan, the benefits and risks of other options, and the benefits and risks of taking no action are explained to a patient in a manner that is understandable to that patient and allows the person to participate and make sound decisions regarding her/his own medical care.

Intended pregnancy – Pregnancy a woman reports as timed well or desired at the time of conception.

Intimate partner violence (IPV) - Physical, sexual, or psychological harm by a current or former partner or spouse. IPV may also be referred to as domestic violence, or family violence.

Long-acting Reversible Contraceptives (LARC) – Methods of birth control that provide effective contraception for an extended period without requiring user action. LARC include intrauterine devices (IUDs), and subdermal contraceptive implants.

Medicaid – The Texas Medical Assistance Program, a joint federal and state program provided for in Texas Human Resources Code Chapter 32 and subject to Title XIX of the Social Security Act (42 U.S.C. §1396 et seq.). Medicaid reimburses for health care services delivered to low-income individuals who meet eligibility guidelines.

Minor – In Texas, a minor is a person under 18 years of age who has never been married and never been declared an adult by a court (emancipated). (See Texas Family Code Section 101.003).

Outreach – Activities that are conducted with the purpose of informing and educating the community about services and increasing the number of individuals served.

Program Income – Monies collected directly by the contractor/provider for services provided under the contract award (i.e., reimbursements from the fee-for-service contract, patient co-pay fees, and donations).

Provider – An individual clinician or group of clinicians who provide services.

Referral – The process of directing or redirecting (as a medical case or a person) to an appropriate specialist or agency for information, help, or treatment.

Reproductive Life Plan – A plan that outlines an individual’s personal goals regarding whether or not to have children, the desired number of children, and the optimal timing and spacing of children. Counseling should include the importance of developing a reproductive life plan and information about reproductive health, family planning methods and services, and obtaining preconception health services, as appropriate.

Texas Medicaid and Healthcare Partnership (TMHP) – The Texas Medicaid Claims and Primary Care Case Management (PCCM) Administrator. HHSC contracts with TMHP to process claims for providers.

Acronyms

ADA	Americans with Disabilities Act
AMA	American Medical Association
A/R	Accounts Receivable
BCCS	Breast and Cervical Cancer Services
CBE	Clinical Breast Exam
CDC	Centers for Disease Control and Prevention
CHIP	Children’s Health Insurance Program
CPT	Current Procedural Terminology
DES	Diethylstilbestrol
EOB	Explanation of Benefit
EDI	Electronic Data Interchange
FPP	Family Planning Program
FPL	Federal Poverty Level

FRR	Financial Reconciliation Report
FSR	Financial Status Report
HHSC	Texas Health and Human Services Commission
HIPAA	Health Insurance Portability and Accountability Act
HIV	Human Immunodeficiency Virus
HPV	Human Papilloma Virus
HSV	Herpes Simplex Virus
HTW	Healthy Texas Women
IRB	Institutional Review Board
IUD	Intrauterine Device
LARC	Long Acting Reversible Contraceptive
LEP	Limited English Proficiency
NPI	National Provider Identifier
NPPES	National Plan and Provider Numeration System
PDPT	Patient-Delivered Partner Therapy
QA	Quality Assurance
QM	Quality Management
PAA	Prescriptive Authority Agreement
SDO	Standing Delegation Orders
STD	Sexually Transmitted Disease
STI	Sexually Transmitted Infection
TAC	Texas Administrative Code
TANF	Temporary Assistance for Needy Families
TMHP	Texas Medicaid Healthcare Partnership
TMPPM	Texas Medicaid Provider Procedures Manual
TPI	Texas Provider Identifier

WIC Special Supplemental Nutrition Program for Women, Infants,
and Children

CLIENT ACCESS

The contractor must ensure that individuals are provided services in a timely and nondiscriminatory manner. The contractor must:

- Have a policy in place that delineates the timely provision of services.
 - Individuals deemed eligible for the Family Planning Program should be given an appointment as soon as possible - no later than 30 days from initial request.
 - Adolescents age 17 and younger should be seen as soon as possible, with every effort made to provide an appointment within two weeks of the request.
 - Clients who request contraception but cannot be immediately provided a clinical appointment must be offered a non-prescription method.
 - Clinic/reception room wait times should be reasonable so as not to present a barrier to service.
- Comply with all applicable civil rights laws and regulations including [Title VI of the Civil Rights Act of 1964](#), the [Americans with Disabilities Act](#) of 1990, the Age Discrimination Act of 1975, and [Section 504 of the Rehabilitation Act of 1973](#), and ensure services are accessible to persons with [Limited English Proficiency](#) (LEP) and speech or sensory impairments at no cost to the person.
- Have a policy in place that requires qualified staff to assess and prioritize an individual's needs.
- Provide referral sources for individuals that cannot be served or cannot receive a specific service.

- Manage funds to ensure that established individuals continue to receive services throughout the budget year.
- Inform individuals of FPP services and encourage them to bring required documentation to the initial visit for eligibility processing.

A qualifying individual seeking family planning services must not be denied services due to an inability to pay.

Contractors have the right to terminate services to an individual if the individual is disruptive, unruly, threatening, or uncooperative to the extent that the individual seriously impairs the contractor's ability to effectively and safely provide services or if the individual's behavior jeopardizes his or her own safety, clinic staff, or others. An individual has the right to appeal the denial, suspension, or termination of services. See Appeal rights: Denial, Suspension, or Termination of Services and Client Appeals (1 TAC §382.111).

Any policy related to termination of services must be included in the contractor's policy manual.

ABUSE AND NEGLECT REPORTING

HHS contractors must comply with state laws governing the reporting of suspected abuse and neglect of children, adults with disabilities, or individuals 65 years of age or older. Contractors must have an agency policy regarding abuse and neglect.

To report abuse or neglect, call the Texas Abuse Hotline **800-252-5400**, use the [secure website](#), or call any local or state law enforcement agency for cases that pose an imminent threat or danger to an individual.

Child Abuse Reporting, Compliance, and Monitoring

Family Code Chapter 261 requires suspected abuse or neglect of a child to be reported. Human Resources Chapter 48 requires suspected abuse, neglect, or exploitation of an elderly person, a person with a disability, or an individual receiving services from certain home and community-based providers to be reported.

Contractors/providers are required to develop policies and procedures that comply with the reporting guidelines and requirements set forth in [Chapter 261 of the Texas Family Code](#).

Policy – Contractors must develop an internal policy specific to:

- how child abuse reporting requirements will be implemented throughout their agency,
- how staff will be trained, and
- how internal monitoring will be done to ensure timely reporting.

Procedures – During Quality Assurance (QA) monitoring, the following procedures will be utilized to evaluate compliance:

- The contractor's process to ensure that staff is reporting abuse as required by Family Code Chapter 261. To verify compliance, QA monitors will review that the contractor:
 - has an internal policy which details how the contractor will determine, document, report, and track instances of abuse, sexual or non-sexual, for all individuals under the age of 18 in compliance with the Texas Family Code, Chapter 261;
 - followed their internal policy; and
 - documented staff training on child abuse reporting requirements and procedures.

- The contractor's internal policy must clearly describe the reporting process for child abuse.

References for child abuse reporting policy development:

Child Abuse Reporting Requirements for DSHS Contractors and Providers; includes links to Policies, Child abuse reporting form, and statutory references. Available at <http://www.dshs.texas.gov/childabusereporting/default.shtm>

Human Trafficking

HHSC mandates that contractors comply with state laws governing the reporting of abuse and neglect. Additionally, as part of the requirement that contractors comply with all applicable federal laws, family planning contractors must comply with the federal anti-trafficking laws, including the Trafficking Victims Protection Act of 2000. ([22 USC §7101, et seq.](#))

Contractors must have a written policy on human trafficking which includes the provision of annual staff training.

References for human trafficking policy development:

Human trafficking into and within the United States: A review of the literature on human trafficking in the US for the [US Department of Health & Human Services](#).

[Polaris Project website](#): Contains links to victim and survivor support and other resources for healthcare providers and victims.

[Polaris Project](#) - Recognize the signs: Provides lists of common identifiable features of human trafficking victims in multiple settings.

[Rescue and Restore Campaign](#) by the US Dept of Health and Human Services. Contains multiple resources for healthcare providers, social service personnel, and law enforcement for identifying and aiding trafficking victims; includes PowerPoint presentations for training purposes.

Domestic and Intimate Partner Violence

[Intimate partner violence \(IPV\)](#) describes physical, sexual, or psychological harm by a current or former partner or spouse. This type of violence can occur among heterosexual or same-sex couples and does not require sexual intimacy. Contractors must have a written policy related to assessment and prevention of domestic and intimate partner violence, including the provision of annual staff training.

CLIENT RIGHTS

Confidentiality

All contracting agencies must be in compliance with the [U.S. Health Insurance Portability and Accountability Act of 1996 \(HIPAA\)](#) established standards for protection of privacy.

A contractor must document the individual's preferred method of follow-up for clinic services (cell phone, email, work phone) and the individual's preferred language. Contractor must verbally assure each individual the right to confidentiality. Contractors must comply with adult and child abuse and neglect reporting laws in Texas. A FPP health-care provider may not require consent for family planning services from the spouse of a married client. (1 TAC §382.125)

Contractors must ensure that all employees and volunteers receive training about client confidentiality during orientation and be made aware that violation of the law in regard to confidentiality may result in civil damages and criminal penalties. A FPP healthcare provider's staff (paid and unpaid) must be informed during orientation of the importance of keeping client information confidential. (1 TAC §382.125(c)). All employees, volunteers, sub-contractors, board members and/or advisory board members must sign a confidentiality statement during orientation.

Minors and Confidentiality

A provider is required to maintain the confidentiality of care provided to a minor and may not disclose confidential information without the documented consent of the minor's legally authorized representative, or the minor when allowed by law. A provider may only disclose confidential information without consent as required by law, such as to report abuse, and with appropriate safeguards for confidentiality.

The HIPAA privacy rule requires a covered entity to treat a "personal representative" the same as the individual with respect to uses and disclosures of the individual's protected health information. (45 CFR §164.502(g)(1)) In most cases, parents are legally considered to be the personal representatives for their minor children, and they can exercise individual rights, such as access to medical records, on behalf of their minor children. (45 CFR §164.502(g)(2) and (3))

Non-Discrimination and Limited English Proficiency (LEP)

HHSC contractors must comply with state and federal anti-discrimination laws. These laws are contained in the Health and Human Services Commission ([HHSC Uniform Terms and Conditions – Grant Version 2.15](#)), Article IX, Section 9.21 (a-f) Civil Rights, the HHSC Special Conditions Version 1.1, Article V, Section 5.06 Services, and Information for Persons with Limited English Proficiency, which are part of a contractor's contract with the State.

Information about non-discrimination laws and regulations can be found on the [HHSC Civil Rights website](#).

Contract Terms and Conditions

To ensure compliance with non-discrimination laws, regulations, and policies, contractors must:

- Sign a written assurance to comply with applicable federal and state non-discrimination laws and regulations;
- Have a written policy that states the agency does not discriminate on the basis of race, color, national origin, including limited English proficiency (LEP), sex, age, religion, disability, or sexual orientation;
- Have a policy that addresses individual rights and responsibilities that is applicable to all individuals requesting family planning services;
- Have procedures for notifying the HHSC Civil Rights Office of any program or service-related discrimination allegation or complaint no more than ten (10) calendar days of the allegation or complaint;
- Ensure that all contractor staff is trained in the contractor's non-discrimination policies, including policies for serving individuals with LEP and individuals with disabilities, and HHSC complaint procedures;
- Notify all individuals who are applying for family planning services of the contractor's non-discrimination policies and complaint procedures; and
- Prominently display civil rights posters in common areas, including lobbies and waiting rooms, front reception desk, and locations where individuals apply for services; posters can be found on the [Civil Rights Office](#) website.

Questions concerning this section and civil rights matters can be directed to the HHSC Civil Rights Office.

Important Information for Former Military Service Members

Women and men who served in any branch of the United States Armed Forces, including Army, Navy, Marines, Air Force, Coast Guard, Reserves or National Guard, may be eligible for benefits and services under other HHSC programs. For more information, please visit the [Texas Veterans Portal](#).

Termination of Services

A qualifying individual seeking family planning services must not be denied services due to an inability to pay. Contractors have the right to terminate services to an individual if the individual is disruptive, unruly, threatening, or uncooperative to the extent that the individual seriously impairs the contractor's ability to effectively and safely provide services or if the individual's behavior jeopardizes his or her own safety, clinic staff, or others. An individual has the right to appeal the denial, suspension, or termination of services. See Appeal rights: Denial, Suspension, or Termination of Services and Client Appeals (1 TAC §382.111).

Any policy related to termination of services must be included in the contractor's policy manual.

Resolution of Complaints

Contractors must ensure that individuals have the opportunity to express concerns about care received and to further ensure that those complaints are handled in a consistent manner. Contractors' policy manuals must explain the process individuals request a hearing, a contractor shall not terminate services to the individual until a final decision is rendered by HHSC (1 TAC §357.13). Any complaint must be documented in the individual's record.

Freedom of Choice

HHSC FPP clients are guaranteed the right to voluntarily choose qualified family planning providers and methods without coercion or intimidation. Acceptance of family planning services must not be a prerequisite to eligibility for or receipt of

any other service or assistance from the entity or individual that provided the service or assistance.

Research (Human Subject Clearance)

A HHSC FPP contractor that wishes to participate in any proposed research that would involve the use of HHSC FPP clients as subjects, the use of HHSC FPP clients' records, or any data collection from FPP clients, must obtain prior approval from their own internal Institutional Review Board (IRB) and HHSC. For information about the process, contractors should contact the Department of State Health Services' (DSHS) IRB at InstitutionalReviewBoard@dshs.texas.gov. The IRB will review the materials and approve or deny the application.

The contractor must have a policy in place that indicates that prior approval will be obtained from HHSC, prior to instituting any research activities. The contractor must also ensure that all staff is made aware of this policy through staff training. Documentation of training on this topic must be maintained.

CLIENT RECORDS MANAGEMENT

HHSC contractors must have an organized and secure client record system. The contractor must ensure that the record is organized, readily accessible, and available to the client upon request with a signed release of information. The record must be kept confidential and secure, as follows:

- Safeguarded against loss or use by unauthorized persons;
- Secured by lock when not in use and inaccessible to unauthorized persons; and
- Maintained in a secure environment in the facility, as well as during transfer between clinics and in between home and office visits.

The written consent of the individual is required for the release of personally identifiable information, except as may be necessary to provide services to the individual or as required by law, with appropriate safeguards for confidentiality. If the individual is 17 years of age or younger, the individual's parent, managing conservator, or guardian, as authorized by Chapter 32 of the Texas Family Code or by federal law or regulations, must authorize the release. HIV information should be handled according to [law](#).

When information is requested, contractors should release only the specific information requested. Information collected for reporting purposes may be disclosed only in summary, statistical, or other form that does not identify particular individuals. Upon request, individuals transferring to other providers must be provided with a copy or summary of their record to expedite continuity of care. Electronic records are acceptable as medical records.

Contractors, providers, subrecipients, and subcontractors must maintain for the time period specified by HHSC all records pertaining to client services, contracts, and payments. Record retention requirements are found in [Title 1, Part 15 TAC §354.1003](#) (relating to Time Limits for Submitted Claims) and [Title 22, Part 9 TAC §165](#) (relating to Medical Records). Contractors must follow contract provisions, maintain medical records for at least seven years after the close of the contract, and follow the retention standards of the appropriate licensing entity. All records relating to services must be accessible for examination at any reasonable time to representatives of HHSC and as required by law.

Contractors must develop and maintain personnel policies and procedures to ensure that clinical staff are hired, trained, and evaluated appropriately for their job position. Personnel policies and procedures must include:

- job descriptions;
- a written orientation plan for new staff to include skills evaluation and/or competencies appropriate for the position; and
- a performance evaluation process for all staff.

Job descriptions, including those for contracted personnel, must specify required qualifications and licensure.

Contractors must show evidence that employees meet all required qualifications and are provided annual training. Job evaluations should include observation of staff/client interactions during clinical, counseling, and educational services.

Contractors shall establish safeguards to prohibit employees from using their positions for a purpose that constitutes or presents the appearance of personal or organizational conflict of interest or personal gain. All employees and board members must complete a conflict of interest statement during orientation. All medical care must be provided under the supervision, direction, and responsibility of a qualified Medical Director. The Family Planning Program Medical Director must be a licensed Texas physician.

Contractors must have a documented plan for organized staff development. There must be an assessment of:

- training needs;

- quality assurance indicators; and
- changing regulations/requirements.

Staff development must include orientation and in-service training for all personnel and volunteers. (Non-profit entities must provide orientation for board members and government entities must provide orientation for their advisory committees). Employee orientation and continuing education must be documented in agency personnel files.

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FACILITIES AND EQUIPMENT

HHSC contractors are required to maintain a safe environment at all times. Contractors must have written policies and procedures that address the handling of hazardous materials, fire safety, and medical equipment.

Hazardous Materials – Contractors must have written policies and procedures that address:

- the handling, storage, and disposing of hazardous materials and waste according to applicable laws and regulations;
- the handling, storage, and disposing of chemical and infectious waste, including sharps; and
- an orientation and education program for personnel who manage or have contact with hazardous materials and waste.

Fire Safety – Contractors must have a written fire safety policy that includes a schedule for testing and maintenance of fire safety equipment. Evacuation plans for the premises must be clearly posted and visible to all staff and clients.

Medical Equipment – Contractors must have a written policy and maintain documentation of the maintenance, testing, and inspection of medical equipment, including automated external defibrillators (AED). Documentation must include:

- assessments of the clinical and physical risks of equipment through inspection, testing, and maintenance;
- reports of any equipment management problems, failures, and use errors;
- an orientation and education program for personnel who use medical equipment; and
- manufacturer recommendations for care and use of medical equipment.

Radiology Equipment and Standards – All facilities providing radiology services must:

- possess a current Certificate of Registration from the Texas Department of State Health Services, Radiation Control Program;
- have operating and safety procedures as required by Title 25, Texas Administrative Code Chapter 289, Texas Regulations for Control of Radiation; and
- post NOTICE TO EMPLOYEES, Texas Regulations for Control of Radiation.

For information on x-ray machine registration, see the [Texas Department of State Health Services, Radiation Control Program](#).

Smoking Ban – Contractors must have written policies that prohibit smoking in any portion of their indoor facilities. If a contractor subcontracts with another entity for the provision of health services, the subcontractor must comply with this policy.

Disaster Response Plan – Contractors must have written and oral plans that address how staff are to respond to emergency situations (i.e., fires, flooding, power outage, bomb threats, etc.). The disaster plan must identify the procedures and processes that will be initiated during a disaster and the staff (position/s) responsible for each activity. A disaster response plan must be in writing, formally communicated to staff, and kept in the workplace available to employees for review. For an employer with ten or fewer employees the plan may be communicated orally to employees.

For additional resources on facilities and equipment, see the [Occupational Safety and Health Administration website](#).

QUALITY MANAGEMENT

Contractors must use internal Quality Assurance/Quality Improvement (QA/QI) systems and processes to monitor FPP services. Contractors must have the ability to meet the management standards prescribed in [45 CFR part 75](#).

Contractors should integrate [Quality Management](#) (QM) concepts and methodologies into the structure of the organization and day-to-day operations. Quality Management programs can vary in structure and organization and will be most effective if they are individualized to meet the needs of a specific agency, services and the populations served.

Contractors are expected to develop quality processes based on four core Quality Management principles that focus on:

- the client;
- systems and processes;
- measurement; and
- teamwork.

Contractors must have a QM program individualized to their organizational structure and based on the services provided. The goals of the quality program should ensure availability and accessibility of services, quality and continuity of care.

A QM program must be developed and implemented that provides for ongoing evaluation of services. Contractors should have a comprehensive plan for the internal review, measurement, and evaluation of services, the analysis of monitoring data, and the development of strategies for improvement and sustainability.

Contractors who subcontract for the provision of services must also address how quality will be evaluated and how compliance with HHSC policies and basic standards will be assessed with the subcontracting entities.

The QM Committee, whose membership consists of key leadership of the organization, including the Executive Director/CEO and the Medical Director, and other appropriate staff where applicable, annually reviews and approves the quality work plan for the organization. (Note: The Medical Director must be a licensed Texas physician)

The Quality Management Committee must meet at least quarterly to:

- receive reports of monitoring activities;
- make decisions based on the analysis of data collected;
- determine quality improvement actions to be implemented; and
- reassess outcomes and goal achievement.

Minutes of the discussion, actions taken by the Committee, and a list of the attendees must be maintained and made available during Quality Assurance/Quality Improvement reviews.

The comprehensive quality work plan at a minimum must:

- include clinical and administrative standards by which services will be monitored;
- include process for credentialing and peer review of clinicians;
- identify individuals responsible for implementing monitoring, evaluating and reporting;
- establish timelines for quality monitoring activities;
- identify tools/forms to be utilized; and
- outline reporting to the Quality Management Committee.

Although each organization's quality management program is unique, the following activities must be undertaken by all agencies providing client services:

- on-going eligibility, billing, and clinical record reviews to ensure compliance with program requirements and clinical standards of care;
- utilization review;

- tracking and reporting of adverse outcomes;
- annual review of facilities to maintain a safe environment, including an emergency safety plan;
- annual review of policies, clinical protocols, standing delegation orders (SDOs), to ensure they are current; and
- performance evaluations to include primary license verification, Drug Enforcement Administration, and immunization status to ensure they are current.

HHSC contractors who subcontract for the provision of services must also address how quality will be evaluated and how compliance with policies and basic standards will be assessed with the subcontracting entities including:

- annual license verification (primary source verification); clinical record review;
- billing and eligibility review;
- utilization review;
- facility on-site review;
- annual client satisfaction evaluation process; and
- child abuse training and reporting – subcontractor staff.

Data from these activities must be presented to the QM Committee. Plans to improve quality should result from the data analysis and reports considered by the committee and should be documented.

PHARMACY

In order to facilitate immediate client access to, and compliance with, contraceptive methods and related medications, contractors must be capable of providing limited pharmaceutical services (including contraceptive methods and related medications) to family planning clients at each clinic site that is funded by the HHSC FPP.

Contractors are required to have at least a Class D pharmacy on-site at each HHSC Title X clinic, have applied for a Class D pharmacy license through the Texas Pharmacy Licensing Board, or have obtained approval for a Class D Pharmacy exemption from HHSC. HHSC staff will verify the license application date and status prior to reviewing a contractor's exemption request.

It is the contractor's responsibility to ensure that all contraceptive methods and related medications approved for reimbursement by the FPP are made available at no additional charge to the individual.

Pharmacies must be operated in accordance with federal and state laws relating to security and record-keeping for drugs and devices. The inventory, supply, and provision of pharmaceuticals must be conducted in accordance with state pharmacy laws and professional practice regulations. It is essential that each facility maintain an adequate supply and variety of drugs and devices on-site to effectively manage the contraceptive needs of its patients.

Class D Pharmacy Exemption

If extenuating circumstances prohibit a license from being granted, or if having an exemption would facilitate client access to contraceptive methods and related medications, a contractor may request an exemption to the requirement to have an on-site pharmacy.

A request for an exemption must be made in writing to the HHSC FPP and will be considered on a case-by-case basis. A request for an exemption is the first step in the process and must 1) describe the process through which a person obtains medication from the referral pharmacy/pharmacies, and 2) include justification wherein referring individuals to an off-site pharmacy benefits the agency and/or individuals.

The following criteria must be met in order to potentially qualify for an exemption:

- A signed and fully executed Memorandum of Understanding (MoU) with referral pharmacy/pharmacies, which includes the purpose of cooperation and details coordination with between the contractors and the referral pharmacy/pharmacies to provide the following medications:
 - non-clinician administered hormonal contraceptive methods [oral contraceptives; transdermal hormonal contraceptives (patch); and vaginal hormonal contraceptives (ring)]; and
 - anti-infectives for the treatment of STIs and other infections.
- The agreement made with referral pharmacy/pharmacies must not create barriers to the individual receiving the prescribed medication.
- The referral pharmacy/pharmacies is/are located within a reasonable distance to participating clients.
- Clients do not incur additional costs (such as a co-payment) to obtain medications.
- The contractor has a written policy that ensures clients can obtain prescribed medication refills from the cooperating pharmacy/pharmacies without an additional clinic visit (unless medically indicated/necessary).

An exemption request will be reviewed by FPP staff and, depending on the justification and circumstances specific to each clinic site, may or may not be granted. The FPP reserves the right to approve or disapprove an exemption request based upon the merit of the justification.

The pharmacy exemption process is not complete until the contractor receives either an approval or a denial from the Program.

A pharmacy exemption does **not** exclude a contractor from providing the following contraceptive methods **on-site**:

- Injectable hormonal contraceptives;
- Barrier methods and spermicides; and
- Counseling and education on sexual abstinence.

CLIENT RECORDS MANAGEMENT

HHS contractors must have an organized and secure client record system. The contractor must ensure that the record is organized, readily accessible, and available to the client upon request with a signed release of information. The record must be kept confidential and secure, as follows:

- Safeguarded against loss or use by unauthorized persons;
- Secured by lock when not in use and inaccessible to unauthorized persons; and
- Maintained in a secure environment in the facility, as well as during transfer between clinics and in between home and office visits.

The written consent of the individual is required for the release of personally identifiable information, except as may be necessary to provide services to the individual or as required by law, with appropriate safeguards for confidentiality. If the individual is 17 years of age or younger, the individual's parent, managing conservator, or guardian, as authorized by Chapter 32 of the Texas Family Code or by federal law or regulations, must authorize the release. HIV information should be handled according to [law](#).

When information is requested, contractors should release only the specific information requested. Information collected for reporting purposes may be disclosed only in summary, statistical, or other form that does not identify particular individuals. Upon request, individuals transferring to other providers must be provided with a copy or summary of their record to expedite continuity of care. Electronic records are acceptable as medical records.

Contractors, providers, subrecipients, and subcontractors must maintain for the time period specified by HHS all records pertaining to client services, contracts, and payments. Record retention requirements are found in Title 1, Part 15 TAC §354.1003 (relating to Time Limits for Submitted Claims) and Title 22, Part 9 TAC §165 (relating to Medical Records). Contractors must follow contract provisions, maintain medical records for at least seven years after the close of the contract, and follow the retention standards of the appropriate licensing entity. All records relating to services must be accessible for examination at any reasonable time to representatives of HHS and as required by law.

ELIGIBILITY AND ASSESSMENT OF CO-PAY/FEES

Client Eligibility Screening Process

HHSC FPP contracted agencies must screen all family planning applicants for eligibility in the following programs that provide family planning services in this order: Medicaid, Healthy Texas Women (HTW), and then the HHSC FPP. Eligibility screening criteria and processes are described below.

Screening for Medicaid

If the individual has a “Your Texas Benefits” Medicaid card, it can be used to document Medicaid eligibility.

Providers can call TMHP at 1-800-925-9126 or log on to [TexMedConnect](#) to check the member’s Medicaid ID number (PCN).

Screening for HTW

All women 15-44 years of age who are not eligible for full Medicaid services must be screened for HTW. HTW is a state-funded program administered by HHSC to provide eligible uninsured women with women’s health and family planning services such as woman’s health exams, health screenings, and birth control. HTW providers must provide clinical services on a fee-for-service basis, and may also, but are not required to, contract with HHSC to provide support services that enhance clinical service delivery on a cost reimbursement basis.

HTW is for women who meet the following qualifications:

- ages 15-44
 - applicants ages 15-17 must have a parent or legal guardian apply, renew, and report changes to her case on her behalf (an applicant is considered 15 years of age the first day of the month of her 15th birthday and 17 years of age through the day before her 18th birthday);

- an applicant is considered 18 years of age on the day of her 18th birthday and 44 years of age through the last day of the month of her 45th birthday;
- U.S. citizens and eligible immigrants;
- reside in Texas;
- do not currently receive full Medicaid benefits, Children’s Health Insurance Program (CHIP), or Medicare Part A or B;
- are not pregnant;
- do not have private health insurance that covers family planning services, unless filing a claim on the health insurance would cause physical, emotional or other harm from a spouse, parent, or other person; and
- have a countable household income at or below 200 percent of the federal poverty level.

How to know if a person is covered by HTW:

If the individual has a “Your Texas Benefits” Medicaid card, it can be used to document Medicaid eligibility.

Providers can call TMHP at 1-800-925-9126 or log on to [TexMedConnect](#) to check the member’s Medicaid ID number (PCN).

Contractors must assist individuals who screen eligible for HTW to complete the HTW Application Form #H1867 and verify the person’s income, identity, and citizenship in accordance with HTW policies. An applicant may qualify as adjunctively eligible if she or a member of her family participates in the Special Supplemental Nutrition Program for Women, Infants, and Children [WIC], Supplemental Nutrition Assistance Program [SNAP], Temporary Assistance for Needy Families [TANF], or Children’s Medicaid. For more information on documents that are acceptable as proof of adjunctive eligibility see the [HTW website](#).

The HTW Application, HHS Form #H1867 is used to apply for HTW if the screening form indicates that a woman is likely to be determined eligible. Note: a HTW Screening Tool or [HTW Application Form #H1867](#) must be maintained in the client record for all potentially eligible HTW individuals.

After ensuring that the application is completed and signed, the contractor must fax the application to the toll-free number included on the application to HHSC for processing. Verification of income, expenses, or adjunctive eligibility, identity, and citizenship must also be faxed with the application. Contractors must fax the application to the eligibility office even if all required documentation is not provided by the individual. The eligibility office will contact the person for any missing information. To minimize paperwork and the chance that verification will be lost, the documents should be photocopied to fit on one sheet, if possible. A woman's enrollment in HTW will be effective from the first day of the month the State receives her application for the program. For example, if a woman applies for HTW on January 20 and she is certified, her enrollment will be effective starting January 1.

Screening for FPP Eligibility

Contractors must determine FPP eligibility. To assess eligibility for FPP services, contractors must use either the Family and Social Services (FSS) Section eligibility form or an FSS Section-approved eligibility screening form substitute (e.g., in-house form, electronic/automated form, phone interview, etc.), that contains the required information for determining eligibility.

The eligibility assessment may be completed over the phone or in the office. The completed eligibility form must be maintained in the individual record, indicating the individual's poverty level and the co-pay amount he or she may be charged. An individual's eligibility must be assessed on an annual basis.

Determining FPP Eligibility

Eligibility Requirements

- Eligible individuals must be:
 - females and males age 64 years and younger;
 - Texas residents. Residency is self-declared. Contractors may require residency verification, but such verification should not jeopardize delivery of services;

- at/or under 250% of the federal poverty level (FPL). Contractors must require income verification. If the methods used for income verification jeopardize the individual's right to confidentiality or impose a barrier to receipt of services, the contractor must waive this requirement. Reasons for waiving verification of income must be noted in the individual record.
- For un-emancipated, unmarried individuals under 18 years of age, if parental consent is required for the receipt of services per Section 32 of the Texas Family Code, the family's income must be considered in determining the charge for the service.
- If parental consent is not required to provide services to an individual under 18 years of age, per Section 32 of the Texas Family Code, only the individual's income is used to assess eligibility, not the income of other family members. In this case, the minor's own income is applied, and the size of the family should be recorded as one.

If a barrier to receiving FPP services exists, the contractor may waive the requirement and approve full eligibility.

For the purpose of determining FPP eligibility, the following definitions will be used:

Household -- The household consists of a person living alone or a group of two or more persons related by birth, marriage including common-law, or adoption, who reside together and are legally responsible for the support of the other person. Household is self-declared.

- For example: If an unmarried applicant lives with a partner, ONLY count the partner's income and children as part of the household IF the applicant and his/her partner have mutual children together. Unborn children should also be included. Treat applicants who are 18 years of age as adults. No children aged 18 and older or other adults living in the household should be counted as part of the household group.
- **Income** -- All income received must be included. Income is calculated before taxes (gross). Include sources of income as defined in the HHSC FPP Definition of Income (See Appendix D).

- For individuals who are married or who are 18 years of age or older, the income of all family members must be used.
- For un-emancipated, unmarried individuals UNDER 18 years of age, if parental consent is required for the receipt of services per Section 32 of the Texas Family Code, the family's income must be considered in determining the charge for the service.
- If parental consent is not required to provide services to an individual UNDER 18 years of age, per Section 32 of the Texas Family Code, only the individual's income is used to assess eligibility, not the income of other family members. In this case, the minor's own income is applied, and the size of the family should be recorded as one.
- **Income Deductions** - Dependent care expenses shall be deducted from total income in determining eligibility. Allowable deductions are actual expenses up to \$200.00 per child per month for children under age 2 and \$175.00 per child per month for each dependent age 2 or older.

Legally obligated child support payments made by a member of the household group shall also be deducted. Payments made weekly, every two weeks or twice a month must be converted to a monthly amount by using one of the conversion factors listed below.

Monthly Income Calculation

- If income is received in lump sums or at longer intervals than monthly, such as seasonal employment, the income is prorated over the period of time the income is expected to cover.
- Weekly income is multiplied by 4.33.
- Income received every two weeks is multiplied by 2.17.
- Income received twice monthly is multiplied by 2.

Re-Screening for HTW

- An applicant must be re-screened at subsequent visits if her eligibility for HTW has not been determined after 45 calendar days from the application submission date.
 - If the applicant seeks services within the 45 days from the application submission date, and the person has undetermined HTW eligibility, then contractors are not required to re-screen for HTW.
- Applicants who were initially screened ineligible for HTW because of their citizenship or immigration status must be re-screened annually or when the individual reports a change in their citizenship or immigration status.
- If the applicant has been deemed ineligible for HTW, a copy of the denial letter must be maintained in the individual's record. Applicants who do not provide a copy of denial letter must be re-screened at subsequent visits.
- Individuals who refuse to apply for HTW must be re-screened at subsequent visits.

Adjunctive Eligibility

An applicant is considered adjunctively (automatically) eligible for HHSC FPP services at an initial or renewal eligibility screening, if she/he is currently enrolled in one of the following programs:

- Children's Health Insurance Program (CHIP), Supplement Nutrition Assistance Program (SNAP),
- Temporary Assistance for Needy Families (TANF), and/or Special Supplemental Nutrition Program for Women, Infants, and Children (WIC).

The applicant must be able to provide proof of active enrollment in the adjunctively eligible program. Acceptable eligibility verification documentation may include:

PROGRAM

DOCUMENTATION

CHIP	<i>'Your Texas Benefits' card*</i>
SNAP	<i>SNAP eligibility letter</i>
TANF	<i>TANF verification of certification letter</i>
WIC	<i>WIC verification of certification letter, printed WIC-approved shopping list, or recent WIC purchase receipt with remaining balance</i>

*NOTE: If the individual has a "Your Texas Benefits" Medicaid card, it can be used to document Medicaid eligibility.

To verify eligibility providers must call TMHP at 1-800-925-9126 or log on to [TexMedConnect](#) to check the member's Medicaid ID number (PCN).

If the applicant or the applicant's child (must be considered part of the household) is enrolled in the Children's Health Insurance Program (CHIP), she/he may be considered adjunctively eligible.

If the applicant's current enrollment status cannot be verified during the eligibility screening process, adjunctive eligibility would not be granted. Contractor would then determine eligibility according to usual protocols.

Calculation of Applicant's Federal Poverty Level Percentage

Household FPL Calculation

If a contractor collects a co-payment, the contractor must determine the applicant's exact household Federal Poverty Level (FPL) percentage. The steps to do so include:

- Determine the applicant's household size.
- Determine the applicant's total monthly income amount.
- Divide the applicant's **total monthly income** amount by the **maximum monthly income** amount at 100% FPL, for the appropriate **household size**.
- Multiply by 100%

The maximum monthly income amounts by household size are based on the Department of Health and Human Services [federal poverty guidelines](#). The guidelines are subject to change around the beginning of each calendar year. For more information, see Appendix E.

Example:

Applicant has a total monthly income of \$2,093 and counts three (3) family members in the household.

Total Monthly Income		Maximum Monthly Income (Household Size of 3)				Actual Household FPL%
\$2,093	÷	\$1,702	=	1.22	x 100%	= 122% FPL

Date Eligibility Begins

An individual is eligible for services beginning the date the contractor determines the individual eligible for the program and signs the completed application.

Client Fees/Co-pays

All FPP services provided at an HHSC FPP Funded clinic, including non-reimbursable services, must be offered on a sliding fee scale. (See example co-pay schedule posted online under the Forms section.)

Please note the following:

- Medicaid-eligible individuals must never be charged a fee for services covered by Medicaid.
- HTW-eligible individuals must never be charged a fee for services covered by HTW.
- HHSC FPP-eligible individuals at or under 100% FPL must never be charged a fee for services covered by the program.
- Individuals must never be denied services because of inability to pay current fees or any fees owed. Signs indicating this policy should be visibly posted at contractor clinic sites.

Co-Pay Guidelines:

- Individuals between 101% and 250% FPL *may* be assessed a co-pay for FPP services. If an individual is charged a co-pay, the co-pay amount must be reflected on the individual's account.
- Individuals may not be charged an additional co-pay for services that are provided by referral.
- Individuals who are assessed a co-pay should be presented with the bill at the time of service.
- Contractors must maintain records regarding individual co-pays paid and any balance owed. Contractors must also have a system for aging accounts receivable. This system must be documented in the contractor's policy and procedures and must clearly indicate a timeframe for removing balances from an individual's account due to inability to pay.

If a contractor opts to charge a co-payment for services, a co-pay schedule must be developed and implemented with sufficient proportional increments so that inability to pay is never a barrier to service. Individuals whose household income is at or below 100% of the FPL must not be charged a co-pay. Individuals whose household income is between 101% and 250% of FPL *may* be charged a co-pay, but it is not required.

- An example of a co-pay schedule is posted online in the Forms section. Contractors can adopt the example or develop their own. The co-pay schedule must have proportional FPL increments and co-pay amounts. The maximum co-pay amount must not exceed \$30.00. The co-pay includes all prescriptions. If a contractor does not use the HHSC FPP example, the scale must be submitted to and approved by the HHSC FPP staff.
- The co-pay schedule must be updated when the revised Federal Poverty Income Guidelines are released.

- Contractors must have policies and procedures regarding co-pay collection, which must be approved by the contractor's Board of Directors.
- Services may be provided to individuals with third-party insurance if the confidentiality of the person is a concern or if the person's insurance deductible is 5% or greater of their monthly income.
- Co-payments collected by the contractor are considered program income and must be used to support the delivery of HHSC FPP services.

Other Fees

Individuals shall not be charged administrative fees for items such as processing and/or transfer of medical records, copies of immunization records, etc.

Contractors are allowed to bill individuals for services outside the scope of FPP reimbursable services, if the service is provided at the individual's request, and the person is made aware of his/her responsibility for paying the charges.

Continuation of Services

Contractors who have expended their awarded FPP funds are required to continue to serve their existing FPP clients.

If other funding sources are used to provide FPP services, the funds must be reported as non-HHSC funds on the monthly State Purchase Voucher (Form 4116) and the quarterly Financial Status Report (FSR) (Form 269A).

CONSENT

General Consent

Contractors must obtain the individual's written, informed, voluntary general consent to receive services prior to receiving any clinical services. A general consent explains the types of services provided and how an individual's information may be shared with other entities for reimbursement or reporting purposes. If there is a period of time of three years or more during which a person does not receive services, a new general consent must be signed prior to reinitiating delivery of services.

Consent information must be effectively communicated to every individual in a manner that is understandable. This communication must allow the person to participate, make sound decisions regarding her/his own medical care, and address any disabilities that impair communication (in compliance with Limited English Proficiency regulations). Only the person receiving services may give consent. For situations when the person is legally unable to consent, a parent (in case of an unemancipated minor) or legal guardian must consent on his/her behalf. Consent must never be obtained in a manner that could be perceived as coercive.

In addition, as described below, the contractor must obtain the informed consent of the person receiving services for procedures as required by the Texas Medical Disclosure Panel.

HHSC contractors should consult a qualified attorney to determine the appropriateness of the consent forms utilized by their health care agency

Procedure Specific - Informed Consent

Sterilization Procedures:

There are two consent forms required for sterilization procedures:

- the Sterilization Consent Form, and
- the Texas Medical Disclosure Panel Consent.

The Sterilization Consent Form

The Sterilization Consent Form is necessary for both abdominal and trans-cervical sterilization procedures in women and vasectomy in men. It is published in the Texas Medicaid Provider Procedures Manual (TMPPM) and is the only acceptable consent form for sterilizations funded by regular Medicaid (Title XIX), HTW, or the HHSC FPP.

An electronic copy of the Sterilization Consent Forms (in English and Spanish) may be found on the [TMHP website](#). It is important that contractors use the most recent Sterilization Consent Form available. Additionally, it is the contractor's responsibility to ensure that the form is complete and accurate prior to submission to TMHP.

In brief, the individual to be sterilized must:

- be at least **21 years old** at the time the consent is obtained;
- be mentally competent;
- voluntarily give his or her informed consent;
- sign the consent form **at least 30 days but not more than 180 days prior** to the sterilization procedure*; and
- may choose a witness to be present when the consent is obtained.

**An individual may consent to be sterilized at the time of premature delivery or emergency abdominal surgery, if at least 72 hours have passed after the individual gave informed consent to sterilization. In the case of premature delivery, the informed consent must have been given at least 30 days before the expected date of delivery.*

The consent form must be signed and dated by the:

- individual to be sterilized;
- interpreter, if one is provided;
- person who obtains the consent; and
- physician who will perform the sterilization procedure.

Informed consent may **not** be obtained while the individual to be sterilized is:

- in labor or in the process of delivering an infant or infants;
- seeking to obtain or obtaining an abortion; or
- under the influence of alcohol or other substances that affect the individual's state of awareness.

Texas Medical Disclosure Panel Consent

The [Texas Medical Disclosure Panel \(TMDP\)](#) was established by the Texas Legislature to 1) determine which risks and hazards related to medical care and surgical procedures must be disclosed by health care providers or physicians to their patients or persons authorized to consent for their patients, and 2) establish the general form and substance of such disclosure. TMDP has developed a List A (informed consent requiring full and specific disclosure) for certain procedures, which can be found in the [Texas Administrative Code \(TAC\)](#).

Contractors that directly perform tubal sterilization and/or vasectomy (both List A procedures), must also complete the [TMDP Disclosure and Consent Form](#). This consent is in addition to the Sterilization Consent Form noted on the previous page.

The required disclosures for tubal sterilization are:

- injury to the bowel and/or bladder;
- sterility;
- failure to obtain fertility (if applicable);
- failure to obtain sterility (if applicable); and
- loss of ovarian functions or hormone production from ovary(ies).

The required disclosures for vasectomy are:

- loss of testicle; and
- failure to produce permanent sterility.

For all other procedures not on List A, the physician must disclose, through a procedure-specific consent, all risks that a reasonable person would want to know about. This includes all risks that are inherent to the procedure (one which exists in and is inseparable from the procedure itself) and that are material (could influence a reasonable person in making a decision whether or not to consent to the procedure).

Consent for Services to Minors

Minors age 17 and younger are required to obtain consent from a parent or guardian before receiving certain medical services. HHSC FPP contractors must have proof of a parent's or guardian's consent prior to providing FPP services to a minor. Proof of consent must be included in the minor's medical record.

Minors may consent to HIV/STD testing and treatment for an STD. Minors may consent to other medical treatment services in certain circumstances, pursuant to Texas Family Code Chapter 32 as outlined below.

For information on health services and consent requirements for minors see: [Adolescent Health – A Guide for Providers](#) and [The Texas Family Code, Chapter 32](#), part of which is outlined below.

Texas Family Code Chapter 32 Sec. 32.003. CONSENT TO TREATMENT BY CHILD: There are instances in which a child may consent to medical, dental, psychological, and surgical treatment for the child by a licensed physician or dentist if the child:

- is on active duty with the armed services of the United States of America;
- is:
 - 16 years of age or older and resides separate and apart from the child's parents, managing conservator, or guardian, with or without

the consent of the parents, managing conservator, or guardian and regardless of the duration of the residence; and

- managing the child's own financial affairs, regardless of the source of the income;
- consents to the diagnosis and treatment of an infectious, contagious, or communicable disease that is required by law or a rule to be reported by the licensed physician or dentist to a local health officer or the Texas Department of Health, including all diseases within the scope of Section 81.041, Health and Safety Code;
- is unmarried and pregnant and consents to hospital, medical, or surgical treatment, other than abortion, related to the pregnancy;
- consents to examination and treatment for drug or chemical addiction, drug or chemical dependency, or any other condition directly related to drug or chemical use;
- is unmarried, is the parent of a child, and has actual custody of his or her child and consents to medical, dental, psychological, or surgical treatment for the child; or
- is serving a term of confinement in a facility operated by or under contract with the Texas Department of Criminal Justice, unless the treatment would constitute a prohibited practice under Section 164.052(a) (19), Occupations Code.

Consent for HIV Tests

Contractors must comply with [Texas Health and Safety Code](#) §81.105 and §81.106 as follows:

[§81.105](#). INFORMED CONSENT

- Except as otherwise provided by law, a person may not perform a test designed to identify HIV or its antigen or antibody without first obtaining the informed consent of the person to be tested.
- Consent need not be written if there is documentation in the medical record that the test has been explained and the consent has been obtained.

§81.106. GENERAL CONSENT

- A person who has signed a general consent form for the performance of medical tests or procedures is not required to also sign or be presented with a specific consent form relating to medical tests or procedures to determine HIV infection, antibodies to HIV, or infection with any other probable causative agent of AIDS that will be performed on the person during the time in which the general consent form is in effect.
- Except as otherwise provided by this chapter, the result of a test or procedure to determine HIV infection, antibodies to HIV, or infection with any probable causative agent of AIDS performed under the authorization of a general consent form in accordance with this section may be used only for diagnostic or other purposes directly related to medical treatment.

CLINICAL POLICY SECTION

This chapter describes the requirements and recommendations for FPP contractors pertaining to the delivery of direct clinical services to patients. In addition to the requirements and recommendations found within this section, contractors should develop protocols consistent with national evidence-based guidelines appropriate to the target population.

All providers must offer the following core family planning services:

- Contraceptive services (pregnancy prevention and birth spacing)
 - Intrauterine devices (IUDs), contraceptive implants, oral contraceptive pills, three-month (medroxyprogesterone) injections, sterilizations, etc.
- Pregnancy testing and counseling
- Health screenings
 - Cervical cancer screening (Pap smears, etc.)
 - Screening for hypertension, diabetes, and elevated cholesterol
- Preconception health (e.g., screening for obesity, smoking, and mental health)
- Sexually transmitted infection (STI) services
 - Chlamydia and gonorrhea screening and treatment
 - HIV screening

COVERED SERVICES

The FPP seeks to promote the general and reproductive health of Texas residents by providing safe and effective family planning services to men and women through 64 years of age who reside in Texas and meet program eligibility requirements.

The following services are covered under the FPP:

- Annual family planning and preventive healthcare visit;

- Pregnancy testing and counseling;
- Contraceptive services, all methods except elective abortion and emergency contraception, including necessary follow-up and surveillance;
- Certain health screening and diagnostic services, as indicated:
 - Screening, diagnosis, and treatment of Cervical Intraepithelial Neoplasia; diagnosis of cervical cancer
 - Breast cancer screening and diagnosis
 - Screening and outpatient treatment for sexually transmitted diseases and infections (STD/STI)
 - HIV screening
 - Chlamydia and gonorrhea screening and treatment
 - Syphilis screening and treatment
 - Limited prenatal care services
 - Recommended immunizations
 - Screening for postpartum depression
 - Diabetes screening
 - Hypertension screening
 - Screening for elevated cholesterol
 - Preconception health (e.g. screening for obesity, smoking, and mental health)

REQUIREMENT FOR DOCUMENTATION OF REPRODUCTIVE HEALTH SERVICES

All individuals should receive services related to reproductive health and/or contraception at least annually. Individuals using long-acting reversible contraception (intrauterine device, implantable hormonal contraceptive agent) and patients who have undergone permanent sterilization may continue to receive services under the program if they meet eligibility requirements.

The guiding principle of the FPP is to improve the reproductive health of women and men to ensure that every pregnancy and every baby are healthy. At each patient encounter, including encounters for treatment of other conditions (e.g., follow up of an abnormal Pap smear), the provider must educate the patient on how the service

being provided relates to reproductive health or contraception, and this must be documented in the patient record.

For individuals who have undergone sterilization, and women who are post-menopausal or have had a hysterectomy, this counseling and documentation are not required when receiving covered services. This must be documented in the medical record at least annually.

Individual Health Records and Documentation of Encounters

Providers must ensure that a patient health record (medical record) is created for every individual who obtains clinical services (also see Section 1, Chapter 4 – Client Records Management).

All patient health records must be:

- A complete, legible, and accurate documentation of all clinical encounters, including those that take place by telephone;
- Written in ink without erasures or deletions; or documented in the Electronic Health Record (EHR) or Electronic Medical Record (EMR);
- Signed by the provider making the entry, including name of provider, provider title, and date for each entry.
 - Electronic signatures are allowable to document provider review of care.
 - Stamped signatures are not allowable.
- Readily accessible to ensure continuity of care and availability to patients; and
- Systematically organized to allow easy documentation and prompt retrieval of information.

The individual health record must include:

- Individual's identification and personal data, including financial eligibility;
- The individual's preferred language and method of communication;
- Individual's contact information, including the best way and alternate ways to reach the person, to ensure continuity of care, confidentiality, and compliance with HIPAA regulations;

- A person's problem list, updated as needed at each encounter, indicating significant illnesses and medical conditions;
- A complete medication list, including prescription and non-prescription medications, as well as dietary supplements, updated at each encounter;
- A complete listing of all medication allergies and adverse reactions, and other allergic reactions, displayed in a prominent place, and confirmed or updated at each encounter; if the person has no known allergies, this should be properly noted.
- Documentation of the individual's past medical history to include all serious illnesses, hospitalizations, surgical procedures, pertinent biopsies, accidents, exposures to blood products, and mental health history;
- A record or history of immunizations, including immunity to rubella based on a history of vaccine or documented serology testing;
- An individual's health risk survey and assessment, including past and current tobacco, alcohol, and substance use/abuse, domestic and/or intimate partner violence and/or abuse (for any positive result, the individual must be offered referral to a family violence shelter in compliance with [Texas Family Code, Chapter 91](#)), occupational and environmental hazard exposure, environmental safety (e.g., seat belt use, car seat use, bicycle helmets, etc.), nutritional and physical activity assessment, and living arrangements, updated as appropriate at each encounter;
- At each encounter, an encounter-relevant history and physical examination pertinent to the person's reason for presentation, with appropriate laboratory and other studies as indicated;
- A plan of care, updated as appropriate, consistent with diagnoses and assessments, which in turn are consistent with clinical findings;
- Documentation of recommended follow-up care, scheduled return visit dates, and follow-up for missed appointments;
- Documentation of informed consent or refusal of services, to include at a minimum:
 - A general consent for treatment;
 - An individual's refusal of testing;
 - Sterilization consent form, if applicable;
 - A completed Texas Medical Disclosure Panel Consent form for any surgical services provided, if applicable;
 - For required or recommended services refused or declined by the person, documentation of the service offered, counseling provided, and the person's decision to decline.
 - Note the following special considerations for adolescent (17 years of age and younger) consent requirements, as required by the Texas Family Code, [Chapter 32](#) and [Chapter 151](#):
 - Adolescents are required to have consent from a parent or guardian prior to receiving certain medical services; proof of parental consent must be included in the minor patient's medical record when required.
 - Adolescents are not required to have parental consent in order to receive pregnancy-related services (including pregnancy

testing), sexually transmitted disease/infection (STD/STI) and HIV testing, or STD/STI treatment.

- Documentation of client counseling and education, with attention to risks identified in the health risk assessment; and
- At every clinic visit, the record must be updated as appropriate, and the reason for the visit, any assessment made, and service provided must be documented.

INITIAL CLINICAL VISIT

At the initial clinical visit, or an early subsequent visit, a comprehensive health history must be taken, to include, in addition to the elements required for the Individual Health Record above: (adapt as appropriate to the gender of the person)

- Reason for the visit and current health status;
- Review of systems with documentation of pertinent positives and negatives; and
- A reproductive health history.
 - For women, this includes menstrual history, complete obstetrical history, sexual activity history (including contraceptive practices, number and gender of partners, sexually transmitted infection/sexually transmitted disease [STI/STD] and HIV history and risk factors, whether currently sexually active), and reproductive life plan.

For men, this includes sexual activity history (including contraceptive practices, number and gender of partners, sexually transmitted infection/sexually transmitted disease [STI/STD] and HIV history and risk factors, whether currently sexually active), and reproductive life plan.

- For women: Cervical and breast cancer screening history, noting any abnormal results and treatment, and dates of most recent testing;
- For women: Other history of gynecological conditions;
- Other history of genital and/or urological conditions;
- Family health and genetic history.

At every subsequent visit, including the annual primary health care and problem visits, the record must be updated as appropriate, and the reason for the visit and current health status documented.

ANNUAL COMPREHENSIVE FAMILY PLANNING VISIT, PHYSICAL EXAMINATION AND TESTING

The annual family planning visit offers an excellent opportunity for providers to address issues of wellness and health risk reduction as well as addressing any current findings or patient concerns. The annual visit must include an update of the person's health record as described in the Individual Health Record section above, as well as appropriate screening, assessment, counseling, and immunizations based on the individual's age, risk factors, preferences, and concerns.

All individuals must undergo a physical examination annually as part of the family planning visit. This can be deferred to a later date if the person's current history and health status do not suggest issues requiring more urgent examination. However, the annual physical examination should not be deferred longer than 6 months, unless the clinician identifies a compelling reason for extended deferral. Such reason must be documented in the individual's record. Any breast or pelvic examination should be performed only with the consent of the person. Individuals must be offered a suitable method of contraception, such as oral contraceptives, without delay even if the physical examination is put off temporarily or an otherwise asymptomatic individual decline any or all components of the examination.

- It is recommended that the family planning visit include all the following components, at least annually, in addition to any other appropriate elements as suggested by history and presenting signs and symptoms (all findings, including tests, results, and the individual's notification of results, should be documented in the medical record, as well as an individual's refusal or other reason for not testing or performing a specified part of the examination):
 - Measurement of height, weight, and blood pressure (BP) screening for hypertension; and
 - Calculation of body mass index (BMI) with assessment for underweight, overweight, or obesity, with counseling (if indicated) on achieving and maintaining a healthy body weight. (An adult [BMI calculator](#) and a [BMI calculator for children and teens](#) are available from the Centers for Disease Control and Prevention.)
- **For females:**

- Clinical breast examination, breast cancer risk assessment, and breast cancer screening as appropriate based on person's age, risk, and preferences;
 - Counseling on breast awareness and advice to report any symptom or sign that is concerning to the individual;
 - Screening for cervical cancer beginning at 21 years of age, regardless of sexual history, and continuing as indicated based on the individual's age, prior test results, and treatment history; and
 - Pelvic examination (for all consenting individuals 21 years and older; only if indicated by the medical history in consenting individuals less than 21 years of age) to include the following elements:
 - Visual examination of the external genitalia, vaginal introitus, urethral meatus, and perianal area;
 - Speculum examination of the cervix and vagina;
 - Bimanual examination of the cervix, uterus, and adnexa; and when indicated, rectovaginal examination.
- **For males:**
 - Visual and manual examination of the external genitalia (scrotum, penis, and testicles) and visual inspection of the perianal area;
 - Assessment for hernia;
 - Palpation of the prostate as indicated by history and person's age; and
 - Advice on testicular awareness and recommendation to report any symptom or sign that is concerning to the person.
 - Other examination as indicated by history, signs and symptoms, and the individual's concerns (e.g., thyroid, heart, lungs, abdomen, etc.):
 - Diabetes screening as appropriate for age and risk factors;
 - Sexually transmitted infections;
 - Pregnancy testing, available on-site (If the pregnancy test is positive, the person must be given information on good health practices during pregnancy and given or referred for appropriate physical evaluation and initiation of prenatal care, preferably within 15 days.);
 - Rubella immunity testing in women of reproductive age if the status cannot be determined by history or previous testing;
 - Cholesterol and/or serum lipid testing;
 - Thyroid stimulating hormone;
 - Immunizations as indicated (Healthcare providers can voluntarily participate in the Texas Department of State Health Services (DSHS) [Adult Safety Net \(ASN\) vaccine program](#), which provides vaccines at no cost); and

- Other testing if indicated.
- Appropriate family planning counseling and treatment;
- Healthy lifestyle interventions and counseling as indicated based on age, risk factors, and client interest and receptiveness.

COUNSELING AND EDUCATION

All individuals must receive accurate person-centered education and counseling in their preferred language, presented in a way they are able to understand and to demonstrate their understanding, and documented in the medical record. The intent of individual education is to enable the person to understand the range of available services and how to access them, to make informed decisions about family planning, to reduce personal health risk, and to understand the importance of recommended tests, health promotion, and disease prevention strategies.

Specific clinical policies must be in place to address counseling and other services provided to adolescents 17 years of age and younger, to include the following, at a minimum:

- Counseling of adolescents must include the following topics:
 - All medically approved methods of contraception, including abstinence;
 - Prevention of STD/STIs and HIV;
 - Domestic, partner, dating, and family violence and the offer of assistance as needed; and
 - Recognition and avoidance of sexual coercion.
- Counseling and clinical services to adolescents must be expedited so that appointments are made available as soon as possible.
- Adolescents must be assured that their privacy and confidentiality will be protected within the parameters of applicable law, including the Health Insurance Portability and Accountability Act (HIPAA), [Texas Family Code, Chapter 32](#), and Section II Chapter 2 (Consent) of this policy manual.

Details of appropriate educational interventions are included in each section of this clinical policy manual. In addition, links are provided to information of use to individuals and educators at the end of most sections.

REQUIREMENTS FOR POLICIES TO ENSURE APPROPRIATE FOLLOW-UP AND CONTINUITY OF CARE

Providers must develop and maintain policies and procedures to ensure proper timely follow-up and continuity of care, to include, at a minimum:

- Tracking pending tests until results are reviewed by provider and the individual is notified of results and recommended follow-up;
- Documentation of all tests and results in the Individual Health Record;
- A mechanism to inform individuals promptly of test results that protects the person's privacy and confidentiality while supporting and promoting timely, appropriate follow-up;
- A mechanism to track individual compliance with recommended follow-up care, schedule return visits, and follow-up on missed appointments; and
- A process to ensure compliance with all applicable state and local laws for disease reporting.

Before a person is considered lost to follow-up, the contractor must make at least three documented separate attempts to contact the person, using an accelerated protocol, where subsequent attempts involve a more intensive effort to contact the person. An example might be a telephone call on the first attempt, a letter by regular mail on the second, and a certified letter on the third. Providers should develop processes that are adapted to the circumstances of the population they serve, and adapt their usual processes based on their knowledge of the circumstances and preferences of the individual they are attempting to contact.

PROBLEM VISITS

For all problem visits, the following elements must be documented in the medical record:

- Reason for the visit
- Appropriate interval medical history and focused history relevant to the problem reported
- Relevant physical examination and testing as indicated, as well as an assessment and treatment prescribed

REFERRALS

When a person is referred to another provider of services for consultation or continuation of care, the chart must reflect a record of the purpose for the referral, the name of the provider consulted or referred to, counseling of the person regarding the purpose of the referral and answering any questions the person has about the referral. Pertinent individual information and appropriate portions of the medical record must be provided to the referral clinician, and this must also be documented in the medical record. The results of the consultation or referral must be followed up on and documented in the medical record.

When services covered under the FPP are to be provided by referral, the contractor must establish a written agreement with a referral resource for the provision of services and reimbursement of costs and ensure that the patient is not charged by the referral resource for these services.

Contractors must maintain a written policy reflecting these requirements for referral activities.

Prescriptive Authority Agreements

When services are provided by Advanced Practice Registered Nurse(s) and/or Physician Assistant(s), it is the responsibility of the contractor to ensure that a properly executed prescriptive authority agreement (PAA), as required by [Texas Administrative Code Title 22, Part 9, Chapter 193, is in place for each such provider](#). This is true whether the provider is employed by the contractor or is providing services by subcontract with or referral by the contractor. The PAA must meet all the requirements delineated in the [Texas Occupations Code, Chapter 157](#), including, but not limited to, the following minimum criteria:

- Be in writing and signed and dated by the parties to the agreement;
- Include the name, address, and all professional license numbers of all parties to the agreement;
- State the nature of the practice, practice locations, or practice settings;
- Identify the types or categories of drugs or devices that may be prescribed, or the types or categories of drugs or devices that may not be prescribed;
- Provide a general plan for addressing consultation and referral;
- Provide a plan for addressing patient emergencies;
- Describe the general process for communication and sharing of information between the physician and the advanced practice registered nurse or physician assistant to whom the physician has delegated prescriptive

- authority related to the care and treatment of individuals;
- If alternate physician supervision is to be utilized, designate one or more alternate physicians who may:
 - Provide appropriate supervision on a temporary basis in accordance with the requirements established by the prescriptive authority agreement and the requirements of this subchapter; and
 - Participate in the prescriptive authority quality assurance and improvement plan meetings required under this section; and
 - Describe a prescriptive authority quality assurance and improvement plan and specify methods for documenting the implementation of the plan that includes the following:
 - Chart review, with the number of charts to be reviewed determined by the physician and advanced practice registered nurse or physician assistant; and
 - Periodic face-to-face meetings between the advanced practice registered nurse or physician assistant and the physician at a location determined by the physician and the advanced practice registered nurse or physician assistant.

The PAA need not describe the exact steps that an advanced practice registered nurse or physician assistant must take with respect to each specific condition, disease, or symptom. The PAA and any amendments must be reviewed at least annually, dated, and signed by the parties to the agreement. A copy of the current PAA must be maintained on-site where the advanced practice registered nurse or physician assistant provides care.

Standing Delegation Orders

When services are provided by unlicensed and licensed personnel, other than advanced practice nurses or physician assistants, whose duties include actions or procedures for a population with specific diseases, disorders, health problems or sets of symptoms, the clinic must have written standing delegation orders (SDOs) in place. SDOs are distinct from specific orders written for a particular individual. SDOs are instructions, orders, rules, regulations or procedures that specify under what set of conditions and circumstances actions should be instituted. The SDOs delineate under what set of conditions and circumstances an RN, LVN, or non-licensed healthcare provider (NLHP) may initiate actions or tasks in the clinical setting and provide authority for use with individuals when a physician or advance practice provider is not on the premises, and/or prior to being examined or evaluated by a physician or advanced practice provider. Example: SDO for assessment of Blood Pressure/Blood Sugar which includes an RN, LVN or NLHP

that will perform the task, the steps to complete the task, the normal/abnormal range, and the process of reporting abnormal values.

Other applicable SDOs when a physician is not present on-site may include, but are not limited to:

- obtaining a personal and medical history;
- performing an appropriate physical exam and the recording of physical findings;
- initiating/performing laboratory procedures;
- administering or providing drugs ordered by voice communication with the authorizing physician;
- providing pre-signed prescriptions for:
 - oral contraceptives;
 - diaphragms;
 - contraceptive creams and jellies;
 - topical anti-infective for vaginal use; or
 - antibiotic drugs for treatment of STI/STDs.
- handling medical emergencies – to include on-site management as well as possible transfer of the individual;
- giving immunizations; or
- performing pregnancy testing.

The SDOs must be reviewed, signed, and dated by the supervising physician who is responsible for the delivery of medical care covered by the orders and other appropriate staff, at least annually and maintained on- site.

References

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Centers for Disease Control and Prevention. Immunization schedules website. Available at (<http://www.cdc.gov/vaccines/schedules/>

FAMILY PLANNING AND CONTRACEPTIVE SERVICES

Reproductive Life Plan

Providers should encourage all individuals to develop a reproductive life plan, which is an outline of each person's immediate and future plans for having children. Questions such as the following can be useful in helping individuals to develop the plan:

- Do you have children now?
- Do you desire to have (more) children?
- How many children would you like to have and when?

Of course, providers and individuals should understand that such plans can change with time. Providers should take the individual's stated plan into account in counseling on contraceptive and family planning services.

- If the person is sexually active and does not desire pregnancy, offer contraceptive services.
- Provide pregnancy testing and counseling to any female who may be pregnant or who requests such testing. Initiate or provide referral for prenatal services if positive.
- If pregnancy is currently desired and the woman is not pregnant, offer services to help her and her partner to achieve a safe and healthy pregnancy.

Contraceptive Counseling and Education

At each encounter for services, individuals must receive patient-centered counseling and education to enable them to make informed decisions about family planning, including information on preventing STD/STIs and HIV, the results of the physical examination and other testing, method-specific counseling as described below, and other counseling as indicated by the history and clinical evaluation.

Providers must offer individuals a wide array of contraceptive options appropriate for the person's health status and reproductive plan. A 6-step approach that seeks to engage the person in the decision-making process while addressing individual personal and cultural preferences will improve individual satisfaction and the likelihood that the selected method will be used correctly and consistently.

- Establish and maintain rapport with the person. Some ways to do this include:
 - Ask open-ended questions.
 - Ensure confidentiality and privacy and explain how confidential information may be used.
 - Listen to and observe the person.
 - Encourage questions and provide culturally sensitive answers that demonstrate knowledge of the subject matter in language the person understands.
- Obtain social and clinical information from the person to include the following:

- Health history;
- Current reproductive life plan;
- Contraceptive experience and possible preferences; and
- Assessment of sexual health:
 - Past and current contraceptive practices;
 - Partner history (e.g., number, gender, whether concurrently monogamous);
 - Current and past STD/STI prevention (e.g., limiting partners, use of condoms, barriers to condom use, consistency of use); and
 - Prior treatment for and possible exposure to STD/STIs.
- Work interactively with the person to choose the most appropriate contraceptive method for the individual.
 - Educate the person about all contraceptive methods that are safe and appropriate for that individual. An online [patient decision support tool](#) is available from the Association of Reproductive Health Professionals.
 - Providers should counsel individuals on the [relative effectiveness of methods](#), correct use of methods, potential non-contraceptive benefits (e.g., reduced risk of iron-deficiency anemia with combination hormonal contraceptives), and method side effects, working with the individual or couple to select the method that best meets their needs and wishes.
 - Individuals should be informed that contraceptive methods other than condoms provide no protection from STD/STIs, including HIV; and that condoms used correctly and consistently do help to reduce the risk of STD/STIs, including HIV.
 - Help the person to identify barriers to correct contraceptive method use and develop solutions to overcome barriers.
- Perform a physical evaluation appropriate to the method chosen, when warranted. In most cases, no physical examination or laboratory testing is necessary prior to initiating a contraceptive method.
 - Blood pressure should be recorded prior to starting combination hormonal contraception.
 - Current pregnancy status should be determined at the time of service for any woman receiving contraceptive services, but routine pregnancy testing is not necessary if it is possible to be reasonably certain that she is not pregnant. A provider may be reasonably certain that a woman is not currently pregnant if she has no signs or symptoms of pregnancy (either intrauterine or ectopic) and meets at least one of the following criteria:
 - ≤ 7 days since the start of a normal menses;

- No sexual intercourse since the beginning of the last normal menses;
 - Has been using a reliable method of contraception correctly and consistently;
 - ≤ 7 days since a spontaneous or induced abortion;
 - ≤ 4 weeks postpartum; or
 - < 6 months postpartum, amenorrheic since delivery, and exclusively or almost exclusively breast feeding (at least 85% of infant feedings are breast feedings).
- Weight assessment is not necessary before initiating a contraceptive method because obesity alone is not a contraindication to any method. However, a baseline weight measurement may aid in assessing the possible effect of a chosen method on weight change.
 - Certain tests and components of the physical examination may provide logistical, economic or emotional barriers to contraceptive access or acceptance for some women. In most cases, many of these interventions can be safely delayed or avoided altogether if necessary, to enable a healthy individual to initiate an appropriate and preferred method (although there may be other healthcare-related indications for the interventions). The following tests and examinations are not necessary prior to initiating a contraceptive method:
 - Pelvic examination, except when fitting a diaphragm or inserting an IUD;
 - Cervical, breast, or other cancer screening;
 - HIV screening;
 - Laboratory testing for hemoglobin, glucose, lipid, or liver enzyme levels; or for thrombogenic mutations; or
 - Any physical examination prior to distributing condoms.
- Once a method of contraception is selected, the provider should provide counseling on correct and consistent use, assist the individual to develop a plan for correct use and follow-up, and confirm the person's understanding. Certain considerations may increase the likelihood of correct and consistent use.
 - Ideally, the method should be dispensed on-site (note on-site pharmacy requirements for contractors in the section below on Specific method access requirements for contractors) and started at the time of the visit (rather than waiting for the next menses), if the provider can be reasonably certain the woman is not pregnant (see item 4.b above for criteria to determine with reasonable certainty that a woman is not currently pregnant).
 - Multiple cycles (ideally a full year's supply) of oral contraceptive pills, the patch, or the ring should be prescribed or provided to reduce the number of return visits necessary.

- Make condoms available easily.
 - Note: All FPP contractors must make barrier methods and spermicides available on-site.
- If the individual's chosen method is not available on-site or immediately, provide another method on the day of the visit to be used until the chosen method can be started.
- Finally, help the person develop a plan for correct and consistent use of the chosen method and provide a plan for follow-up.
 - Explore possible reasons for incorrect or inconsistent use and help develop strategies to deal with these. For example:
 - Suggest a daily text message or a sign on the bathroom mirror to routinize daily pill taking.
 - Discuss ways to ensure timely return for injections.
 - Discuss side effects, a common reason for method discontinuation, and ways to deal with these.
 - Create a follow-up plan with the person, taking into account the person's individual needs and perceived risk of method lapse or discontinuation.
 - Confirm the person's understanding of the information given and document this in the medical record.
 - The teach-back method, in which the individual demonstrates understanding of the information by repeating back the messages received, is a good way to confirm understanding and to increase retention of the information received.
 - Provide counseling with teach-back of the following topics, at a minimum:
 - Real-world method effectiveness;
 - Correct method use and common side effects;
 - Back-up contraceptive methods, including issues related to discontinuation of the chosen method;
 - Whether or not the method protects against STD/STIs;
 - Signs of rare, but serious, complications, and what to do if any of these signs occurs;
 - How to seek urgent or emergency care, including a 24-hour emergency telephone number; and
 - When to return for follow-up.

Relative Method Effectiveness

The following contraceptive methods are approved for reimbursement under the Family Planning (FP) Program. (Note: pharmacy requirements for FPP contractors to be found in Section I Chapter 8, and below on specific method access requirements for contractors).

It is the contractor's responsibility to ensure that all contraceptive methods approved for reimbursement by the FPP are made available at no additional charge to the individual.

Relative method effectiveness (range of effectiveness for 100 women using the method for 1 year) is indicated in parentheses, if reported values are available. Actual effectiveness depends on correctness and consistency of use. Higher rates of effectiveness are seen with perfect use; real-world effectiveness is generally reflected in the lower end of the effectiveness range.

- Extremely effective (~99%)
 - Total sexual abstinence;
 - *Contraceptive implant;
 - *Intrauterine device; and
 - Male or female sterilization.
- Less effective (ranges of effectiveness are shown where the source used provides a range or multiple sources provide differing rates or ranges):
 - Lactational amenorrhea (98-99%; must be < 6 months postpartum, amenorrheic, and providing 85-100% of infant feedings as breast feedings)
 - Progestin injection (Depo-Provera, 94-97%)
 - Hormonal contraceptive pills (91-92%)
 - Hormonal contraceptive patch (91-92%)
 - Vaginal ring (91-92%)
 - Diaphragm (82-88%)
 - Male condom (82-85%)
 - Female condom (79%)
 - Withdrawal ("pulling out," 78-82%)
 - Cervical cap (71-86%)
 - Fertility awareness ("rhythm," 75-76%)
 - Spermicide (71-72%)
 - Sponge (68-88%, more effective in parous women)

***Long-Acting Reversible Contraceptive (LARC) Methods**

Because of their safety, reversibility, ease of use, and very high real-world effectiveness, providers are encouraged to make long-acting reversible contraceptive (LARC) agents and devices (i.e., the intrauterine device and the subdermal contraceptive implant) available to all who are candidates for their use. See the web page [Long-Acting Reversible Contraception Program](#) from the American Congress of Obstetricians and Gynecologists for information and resources on the use of LARCs.

For more information on implementing a program to provide LARCs, see the [Texas LARC Toolkit](#) on the [Healthy Texas Women](#) website.

Consent for Sterilization

For individuals who choose male or female sterilization, 2 consent forms are required to be signed by the person after counseling on method-specific risks and benefits is provided and all the person's questions have been answered:

- The [Sterilization Consent Form](#) must be signed by the person at least 30 days and not more than 180 days prior to the procedure. An exception is made if the person undergoes emergency abdominal surgery or preterm birth, in which case, the form must be signed at least 72 hours before the sterilization procedure (and at least 30 days prior to the expected date of delivery if preterm birth is the reason for the exception).
- A [Texas Medical Disclosure Panel Consent](#) for the surgical procedure by which sterilization will be performed must be signed by the person after full disclosure of the risks and possible benefits is provided and all the patient's questions are answered.

Specific Method Access Requirements for Contractors

- LARC methods (i.e., the intrauterine device and the subdermal contraceptive implant) must be available on-site or by referral.
- Male and female sterilization must be made available, subject to program funding stipulations.

- All contractors must make injectable hormonal contraceptive agents, male and female condoms, spermicides, diaphragm, contraceptive sponge, cervical cap, and counseling and education on sexual abstinence available on-site.
- Contractors who are subject to the requirement to maintain a class D pharmacy must also make oral and transdermal hormonal contraceptive agents or vaginal hormonal contraceptive ring available on-site.

The table below outlines the requirements for on-site availability of contraceptive methods and anti-infective agents for FPP contractors:

Contraceptive Method or Anti-infective Agent	On-site Availability Required	
	Class D Pharmacy	Class D Pharmacy Exempt
Anti-infective agents for treatment of STD/STIs	•	
Barrier methods and spermicides	•	•
Injectable hormonal contraceptives	•	•
Oral contraceptives	•	
Transdermal hormonal contraceptive (patch) and/or vaginal hormonal contraceptive (ring)	•	
Sexual abstinence education and counseling	•	•

Contraceptive Methods that may be provided by Referral

If the clinicians associated with a FPP contractor do not provide covered contraceptive services that require a special level of training or expertise (e.g., sterilization, intrauterine device, hormonal implant, and diaphragm fitting), these services may be offered by referral to another provider at no additional cost to the individual. FPP contract clinics that offer such services by referral must have a written agreement with the referral provider to offer the method or service under this condition.

Note:

- Abortion is not considered a method of family planning and no state funds appropriated to the department shall be used to pay the direct or indirect costs (including overhead, rent, phones and utilities) of abortion procedures provided by contractors.
- Emergency contraceptive pills (EC or ECP) and related provider services are not reimbursable under the FPP.

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Centers for Disease Control and Prevention. U.S. selected practice recommendations for contraceptive use, 2016. *MMWR* 65(No. 4). Available at <https://www.cdc.gov/reproductivehealth/contraception/mmwr/spr/summary.html> (web) <https://www.cdc.gov/mmwr/volumes/65/rr/pdfs/rr6504.pdf> (PDF)

Resources for Patients and Educators

Association of Reproductive Health Professionals. Method Match. Online decision support tool to help patients compare and select from different methods of contraception; includes information on relative effectiveness of methods. Available at <http://www.arhp.org/methodmatch/>

Resources for Providers

American Congress of Obstetricians and Gynecologists. Long-acting reversible

contraception program web page. Provides information, clinical guidance, and educational materials on Long-acting reversible contraceptives [LARCs]. Available at https://www.acog.org/About_ACOG/ACOG_Departments/Long_Acting_Reversible_Contraception

PRECONCEPTION SERVICES

The goal of preconception care is optimizing the health of every woman to lay the foundation for the best possible outcome of every pregnancy. Because almost half of all pregnancies in the United States are unplanned, and most pregnancies occur in women who did not have a specific preconception care visit prior to becoming pregnant, providers should keep preconception care in mind at every encounter with a woman of childbearing potential.

Good preconception care incorporates all components of general health care as described elsewhere in this manual. Attention should be paid to the following components:

- Optimization of known chronic medical conditions, such as diabetes, hypertension, thyroid disease, epilepsy, asthma, etc.
 - A normal hemoglobin A1c prior to and early in pregnancy can substantially reduce the risk of birth defects in the offspring of mothers with Type 1 and Type 2 diabetes.
 - Women with hyperthyroidism or hypothyroidism should be treated as necessary to ensure that they are euthyroid prior to and during pregnancy to reduce the risk of miscarriage and preterm birth.
 - Women with a history of phenylketonuria should be counseled on the need to follow a low-phenylalanine diet before and during pregnancy to reduce the risk of birth defects and serious developmental delay in the offspring.
- Screening as indicated for any conditions that may be undiagnosed;
- Confirming that immunizations are current;
- Medications (prescription and nonprescription) and potential radiation exposure in early pregnancy:
 - In general, the lowest effective dose of necessary medications is preferred, but individuals should be cautioned against discontinuing or changing medications without first consulting their doctor, because an untreated or incompletely treated medical condition may pose greater risk to the fetus and mother than the medication prescribed.

- Some known teratogenic medications include warfarin, valproic acid, carbamazepine, isotretinoin, and angiotensin-converting enzyme inhibitors.
 - For more individual and provider information on risk associated with specific exposures to medications and other environmental factors, consult the web site of the [Organization of Teratology Information Specialists](#).
- Prevention of STD/STIs;
 - Nutrition and food insecurity;
 - Occupational and environmental exposures to health risks and teratogens;
 - Tobacco and substance use, other high-risk behaviors;
 - Family medical history and genetic risk;
 - Domestic, intimate, and partner violence;
 - Social issues, such as homelessness; and
 - Mental health.

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American College of Obstetricians and Gynecologists. Committee opinion 313: The importance of preconception care in the continuum of women's health care. *Obstet Gynecol* (2005). 106: 665-666. Available at [http://www.acog.org/Resources And Publications/~link.aspx?id=75AD1BF47A76489F8E719EA5E3F22797&z=z](http://www.acog.org/Resources_And_Publications/~link.aspx?id=75AD1BF47A76489F8E719EA5E3F22797&z=z)

Centers for Disease Control and Prevention. Recommendations to improve preconception health and health care – United States. *MMWR* (2006). 55(RR06): 1-23. Available at <http://www.cdc.gov/mmWR/PDF/rr/rr5506.pdf>

Organization of Teratology Information Specialists. Mother To Baby: Medications & more during pregnancy & breastfeeding. Available at <http://mothertobaby.org/fact-sheets-parent/> (provides information for patients and health care providers on teratogenic risk of drugs and other exposures in pregnancy)

Resources for Patients and Providers

American Society for Reproductive Medicine. <http://www.reproductivefacts.org/> (information for patients on a variety of topics related to fertility and infertility)

Centers for Disease Control and Prevention. Content of care for women website. Available at <http://www.cdc.gov/preconception/careforwomen/index.html>

Centers for Disease Control and Prevention. Clinical content of care for men website. Available at <http://www.cdc.gov/preconception/careformen/index.html>

Centers for Disease Control and Prevention. Preconception health and health care web site. Contains links to resources for patients, providers, and patient educators on planning for a healthy pregnancy. Available at <http://www.cdc.gov/preconception/index.html>

CERVICAL CANCER SCREENING

Note that the summary of cited guideline recommendations provided in this section reflect the ages of eligibility for the FPP, and do not include guideline recommendations for individuals outside this range.

In writing this summary, guidelines from a variety of medical specialty organizations and US government agencies were reviewed. Where slight divergence was found among guidelines from different organizations, an attempt was made to synthesize the recommendations so that all recommendations are represented cohesively in the summary below.

The majority of cases of cervical cancer occur in women who have never had screening or have had inadequate screening. It is estimated that half of women who receive a diagnosis of cervical cancer have never had cervical cytology testing, and an additional 10% have not had screening in the 5 years prior to the diagnosis of cancer. Providers are encouraged to implement and participate in programs aimed at increasing the percentage of women in their communities who receive indicated cervical cancer screening.

General Considerations

- Cervical cancer screening should begin at 21 years of age. Except for women who are infected with HIV or otherwise immunocompromised, screening should not be performed prior to age 21.
- Women with the following risk factors are at higher risk and may require more frequent screening than described in this policy manual, which is intended for women of average risk:
 - Women with HIV infection or other reason for immunocompromise (e.g., history of solid organ transplant)
 - History of in utero exposure to diethylstilbesterol
 - Prior treatment for CIN 2, CIN 3, or cervical cancer.
- Either liquid-based or conventional (PAP smear) methods of cervical cytology are acceptable.
- When human papillomavirus (HPV) testing is performed, it should include testing to detect only those HPV genotypes with known carcinogenic potential, so-called high-risk HPV genotypes. Testing for low-risk genotypes, those without demonstrated carcinogenic potential, should not be performed. References to HPV testing in the remainder of this topic section are for high-risk HPV only.
- Screening guidelines should be applied to women who have received the HPV vaccine in the same way as for women who have not received the vaccine.

Screening Frequency and Response to Abnormal Findings

- Routine annual cervical cancer screening is not appropriate for women of average risk in any age group.
- Women 21-29 years of age should undergo screening every 3 years by cervical cytology testing alone, with reflex human papillomavirus (HPV) testing when cytology reveals atypical squamous cells of undetermined significance (ASCUS). Cotesting (cervical cytology combined with routine HPV testing) should not be performed in women younger than 30 years of age.
- For women 25-29 years of age, the FDA-approved primary HPV screening test may be considered as an alternative to cytology-based screening, although cytology alone with reflex HPV testing when cytology reveals ASCUS is recommended by major professional society guidelines. If the primary HPV test is to be used for screening, it should be done according to interim guidance provided by the American Society for Colposcopy and Cervical Pathology and the Society of Gynecologic Oncology.
- For women 30-64 years of age, published guidelines recommend screening by any of three methods:
 - Cotesting (combined cervical cytology and HPV testing) every 5 years
 - Cervical cytology testing alone, with reflex HPV testing when cytology reveals ASCUS, every 3 years

- Screening with the FDA-approved primary HPV screening test every 5 years; if the primary HPV test is to be used for screening, it should be done according to interim guidance provided by the American Society for Colposcopy and Cervical Pathology and the Society of Gynecologic Oncology.
- It is reasonable to perform annual cervical cytology testing in women with in utero exposure to diethylstilbestrol.
- For any individual with an abnormal result, further testing and follow-up should be dictated by findings, diagnosis, and current evidence-based guidelines, such as that of the American Society for Colposcopy and Cervical Pathology.

Discontinuation of Screening

- For women in the FPP age group, screening should be discontinued after a hysterectomy with removal of the cervix in individuals with no prior history of CIN 2 or greater.

References

American Society for Colposcopy and Cervical Pathology (2013). Consensus guidelines for managing abnormal cervical cancer screens & CIN/AIS. Available at <http://www.asccp.org/asccp-guidelines>

Huh, W. K., Ault, K. A., Chelmow, D., Davey, D. D., Goulart, R. A., Garcia, F. A., Einstein, M. H. (2015). Use of primary high-risk human papillomavirus testing for cervical cancer screening: Interim clinical guidance. *Gynecol Oncol*, 136(2), 178-182.

Practice Bulletin No. 168: Cervical cancer screening and prevention. (2016). *Obstet Gynecol*, 128(4), e111-e130.

US Department of Health and Human Services Panel on opportunistic infections in HIV-infected adults and adolescents. Guidelines for the prevention and treatment of opportunistic infections in HIV-infected adults and adolescents: recommendations from the Centers for Disease Control and prevention, the National Institutes of Health, and the HIV Medicine Association of the Infectious Diseases Society of America. Available at <https://aidsinfo.nih.gov/guidelines/html/4/adult-and-adolescent-opportunistic-infection/0>

US Preventive Services Task Force, Curry, S. J., Krist, A. H., Owens, D. K., Barry, M. J., Caughey, A. B.,...Wong, J. B. (2018). Screening for cervical cancer: US Preventive Services Task Force Recommendation Statement. *JAMA*, 320(7), 674-686.

BREAST CANCER SCREENING

Note that the summary of cited guideline recommendations provided in this section reflect the ages of eligibility for the FPP, and do not include guideline recommendations for individuals outside this range.

Risk Screening and Individual Counseling

All females should have an assessment of their risk for breast cancer, updated periodically, to include the individual's age and ethnicity, personal and family history of breast cancer, other relevant genetic predisposition to breast cancer, and any history of chest radiation (particularly before age 30). A [risk calculator](#) for the individual 5-year risk of developing breast cancer for women 35 years of age and older is available from the National Cancer Institute.

All individuals should be counseled on breast awareness and advised to be familiar with their breasts and to report any changes (such as a mass, lump, thickening, or nipple discharge) promptly.

Screening Frequency

The following considerations* apply to women 40 years of age and older who do not have a preexisting breast cancer or other high-risk breast lesion and who do not have a known underlying genetic mutation (such as a BRCA1 or 2 mutations, or other familial breast cancer syndrome) or a history of chest radiation at an early age.

- All individuals 50-64 years of age should be offered screening mammography every other year.
- The decision for screening mammography in women 40-49 years of age should be individualized:

- While screening mammography may reduce breast cancer-related deaths in this population, the number of deaths prevented is less than in older populations and the number of false-positive mammography results and negative biopsies is higher.
 - Women who undergo regular screening mammography face a risk of the diagnosis and subsequent treatment of breast cancer that would not otherwise have become apparent or threatened their health during their lifetime (overtreatment).
 - Women with a first-degree relative (parent, sibling, or child) with breast cancer are at increased risk and may benefit more from screening in their 40s than average-risk women.
 - Women who place a higher value on the potential benefits of screening than on the potential harms may choose, and should be allowed, to undergo biennial screening beginning sometime between age 40 and 49.
- Digital mammography combined with breast tomosynthesis may improve the rate of cancer detection and decrease call-back rates in some women, although this practice may increase the total radiation dose.
 - There is insufficient evidence to assess the balance of benefits and harms for the use of breast ultrasonography, magnetic resonance imaging, or other methods of adjunctive screening in women with dense breasts identified on an otherwise negative screening mammogram.

More frequent or earlier screening mammography may be considered in women with increased or uncertain individual breast cancer risk and in other circumstances where the balance of potential benefits and harms of screening is felt to justify it.

*Note that the recommendations for frequency of mammography screening described above come from the US Preventive Services Task Force Recommendation Statement on Screening for Breast Cancer. The National Comprehensive Cancer Network recommends annual screening mammography be offered to all asymptomatic women 40 years of age and older. Links to both guidelines are provided in the References section immediately below.

Follow-up and Referral for Treatment

Any individual with an abnormality identified on screening or a specific breast complaint (including, but not limited to, a mass, lump, thickening, or nipple discharge) should be evaluated as indicated in a timely manner. Providers should have procedures in place to ensure appropriate individual education and counseling, referral for further evaluation (including additional testing and biopsy) when

indicated, communication and coordination with the person and other providers, and proper follow-up through the conclusion of the case.

For persons who require referral for services beyond those available through the contracted provider, contractors are encouraged, whenever possible, to refer to a HHSC Breast and Cervical Cancer Services (BCCS) contractor. Information is available at <https://hhs.texas.gov/Doing-Business-HHS/Provider-Portals/Health-Services-Providers/Womens-Health-Services/Breast-Cervical-Cancer-Services>

Eligible individuals in need of treatment for biopsy-proven breast cancer may apply for coverage under the Medicaid for Breast and Cervical Cancer Program. Information is available at <https://hhs.texas.gov/doing-business-hhs/provider-portals/health-services-providers/womens-health-services/breast-cervical-cancer-services/breast-cervical-cancer-treatment-information>

References

Siu, AL. Screening for breast cancer: US Preventive Services Task Force Recommendation Statement. *Ann Intern Med.* 2016;164(4):279-296. Available at <http://annals.org/article.aspx?articleid=2480757> (web)

National Comprehensive Cancer Network. (2018). NCCN clinical practice guidelines in oncology: Breast cancer screening and diagnosis. Version 2.2018. Available at https://www.nccn.org/professionals/physician_gls/f_guidelines.asp#breast_screening

Additional Reading

National Comprehensive Cancer Network. (2018). NCCN clinical practice guidelines in oncology: Breast cancer risk reduction. Version 2.2018. Available at https://www.nccn.org/professionals/physician_gls/f_guidelines.asp#breast_risk

National Comprehensive Cancer Network. (2017). NCCN clinical practice guidelines in oncology: Genetic/familial high-risk assessment: Breast and ovarian. Version 1.2018. Available at https://www.nccn.org/professionals/physician_gls/f_guidelines.asp#breast_risk

Information for Patients

National Cancer Institute. Mammograms patient information page. Available at <http://www.cancer.gov/types/breast/mammograms-fact-sheet>

National Cancer Institute. Breast Cancer – Patient Version. Available at <http://www.cancer.gov/types/breast>

Online Provider Resources

National Cancer Institute. Breast Cancer Risk Assessment Tool. Available at <http://www.cancer.gov/bcrisktool/Default.aspx>

SEXUALLY TRANSMITTED DISEASE/INFECTION (STD/STI) SCREENING AND TREATMENT

Note that the summary of cited guideline recommendations provided in this section reflect the ages of eligibility for the FPP, and do not include guideline recommendations for individuals outside this range.

Screening and treatment of STD/STIs must follow the current guidelines for [screening](#) and [treatment](#) from the Centers for Disease Control and Prevention (CDC). A risk assessment should be done for all individuals to determine what testing is indicated and documented in the medical record. Following is a brief overview of STD/STI screening recommendations (for more detailed information, go to the CDC screening link above):

- **HIV Screening:**
 - Contractors must provide HIV testing, either on-site or by referral.
 - If HIV testing is done, verbal or written consent should be documented in the medical record. If testing is indicated and the person declines, this should be documented.
 - All individuals 13 to 64 years of age should be screened at least once for [HIV](#), using a policy that provides HIV education and allows

individuals to opt out of screening if desired. With opt-out screening, individuals are informed, prior to testing, that HIV testing will be done as part of the general consent for care and they are free to decline testing if they choose to do so; if they do not decline, the test is performed.

- Individuals who engage in risky sexual practices or share injection drug paraphernalia should be tested annually.
- Individuals who seek testing or treatment of STD/STIs should be tested for HIV at the same time.
- Contractors may provide negative HIV test results to individuals in person, by telephone, or by the same method or manner as the results of other diagnostic or screening tests. The provision of negative test results by telephone must follow procedures that address a person's confidentiality, identification of the person, and prevention counseling.
- Contractors must always provide positive HIV test results to individuals in a face-to-face encounter with an immediate opportunity for counseling and referral to community support services. Test results must be provided by staff knowledgeable about HIV prevention and HIV testing.
- Individuals whose risk assessment reveals high-risk behaviors should be provided directly or referred for, more extensive risk reduction counseling by a Department of State Health Services (DSHS) HIV/STD Program trained risk reduction specialist.
- Persons with a diagnosis of HIV should be referred to a DSHS HIV/STD Program contractor for treatment and monitoring.
- To find a DSHS HIV/STD Program contractor, visit the [DSHS HIV/STD website](#).

- **Chlamydia and Gonorrhea Testing:**

- Chlamydia and gonorrhea screening must be provided by contractors.
- Annual chlamydia and gonorrhea screening should be provided for all sexually active women under 25 years of age. If a pelvic examination will not be performed, as in asymptomatic women under 21 years of age and other women who decline a pelvic examination, screening can be performed using a nucleic acid amplification technique on a urine sample or a patient self-obtained vaginal swab.
- Testing should also be done in older asymptomatic women with increased risk and in all symptomatic women. Indications include, but

are not limited to:

- New or multiple sex partners;
 - A partner who has other partner;
 - Exposure to an STD/STI;
 - Symptoms or signs of cervicitis or an STD/STI;
 - History of pelvic inflammatory disease;
 - A positive test for an STD/STI in the prior 12 months; and
 - Sex work or drug use.
- Treated individuals should be retested approximately 3 to 4 months after treatment to assess evidence of reinfection.
 - All women who are pregnant or attempting pregnancy should be tested.
 - Routine screening of males for chlamydia and gonorrhea is not recommended but should be considered in settings where the prevalence of infection is high such as correctional facilities and adolescent clinics.

- **Herpes Simplex Virus (HSV) Screening:**

- Routine screening of asymptomatic individuals for genital herpes simplex virus (HSV) infection is not recommended in the general or pregnant population.
- Testing, counseling, and treatment of symptomatic individuals (i.e., presence of genital lesions), as well as management of affected pregnant individuals, should follow current [CDC guidelines](#).
- The preferred tests for confirmation of the diagnosis in individuals with active genital ulcers or mucocutaneous lesions are cell culture and polymerase chain reaction (PCR) assay.
- Type-specific serologic testing may be appropriate in some circumstances:
 - For men and women presenting for evaluation of an STD/STI (especially those who report multiple sexual partners), and persons with HIV infection;

- For men who have sex with men and unknown HSV infection status, type-specific serologic testing may be appropriate in the evaluation of an undiagnosed genital tract infection;
- When the diagnosis is suspected, but no lesions are present (a culture or PCR assay is not indicated if no lesions are present);
- When the diagnosis is uncertain and virologic tests (i.e., culture and PCR) are negative in a symptomatic patient; or
- For counseling patients regarding the risk of infection by a partner with known infection, especially during pregnancy.

- **Syphilis screening (men and non-pregnant women):**

- Men and non-pregnant women who are at increased risk of syphilis infection should undergo screening for syphilis.
- Men who have sex with men, and men and women who are living with HIV, have the highest risk for syphilis infection.
- Other factors associated with increased prevalence of syphilis infection are a history of incarceration or commercial sex work.
- According to 2014 surveillance data, approximately 91% of cases of syphilis occurred in men, with the highest rates in men 20 to 29 years of age.
- Syphilis prevalence (per 100,000 population) in the U.S. varied by race and ethnicity in 2014:
 - Black: 18.9
 - Hispanic and American Indian/Alaska Native: 7.6
 - Native Hawaiian/Pacific Islander: 6.5
 - White: 3.5
 - Asian: 2.8
- Routine screening for syphilis in a non-pregnant population that is not at increased risk of syphilis infection is not recommended because it may yield a high false-positive rate, leading to overtreatment.

- Screening for other infections and more frequent screening should be considered as appropriate based on the person's condition, risk factors, and concerns.
- Pregnant women:
 - All pregnant women should undergo screening for syphilis, HIV (by an [opt-out](#) policy), and hepatitis B surface antigen as early as possible in the pregnancy.
 - Individuals under 25 years of age, and women at increased risk should also have chlamydia and gonorrhea testing.
 - Repeat testing in the third trimester is recommended for individuals at increased risk of new infection.

Patient-Delivered Partner Therapy

Patient-Delivered Partner Therapy (PDPT) is the practice of providing therapy to the sexual partner(s) of a person being treated for chlamydia or gonorrhea without first developing a patient-clinician relationship with the partner(s). Untreated partners can reinfect treated individuals and expose others to infection.

Providers are encouraged to implement PDPT by providing individuals who are being treated for either chlamydia or gonorrhea with medications or prescriptions the partner(s) can use to be treated as well.

Providers may not receive reimbursement for providing partner treatment under this policy to persons who have not been seen as patients.

References

American College of Obstetricians and Gynecologists. Committee Opinion No. 598: The initial reproductive health visit. *Obstet Gynecol* (2014) 123: 1143-1147. Available at http://www.acog.org/Resources_And_Publications/Committee_Opinions/Committee_on_Adolescent_Health_Care/The_Initial_Reproductive_Health_Visit

Branson, BM., et al. Revised recommendations for HIV testing of adults,

adolescents, and pregnant women in health-care settings. *MMWR* (2006) 55(RR14): 1-17. Available at <http://www.cdc.gov/mmwr/preview/mmwrhtml/rr5514a1.htm>

Centers for Disease Control and Prevention. Genital herpes. Available at <http://www.cdc.gov/std/Herpes/default.htm>

Centers for Disease Control and Prevention. Pregnant women, infants, and children: An opt-out approach to HIV screening. Available at <http://www.cdc.gov/hiv/group/l/pregnantwomen/opt-out.html>

Centers for Disease Control and Prevention. Sexually transmitted diseases: Treatment. Available at <http://www.cdc.gov/std/treatment/default.htm>

Centers for Disease Control and Prevention. STD & HIV Screening Recommendations. Available at <http://www.cdc.gov/std/prevention/screeningrecs.htm>

U.S. Preventive Services Task Force. Screening for syphilis infection in non-pregnant adults and adolescents: U.S. Preventive Services Task Force recommendation statement. *JAMA* (2016) 315(21): 2321-2327. Available at <http://jamanetwork.com/journals/jama/fullarticle/2526645>

Expedited (Patient-Delivered) Partner Therapy (information for Patients and Providers):

Centers for Disease Control and Prevention. Expedited partner therapy website. Available at <http://www.cdc.gov/std/ept/>

Texas Dept. of State Health Services. Expedited partner therapy website. Available at <http://www.dshs.state.tx.us/hivstd/ept/default.shtm>

HEALTHY LIFESTYLE INTERVENTION

All individuals should receive a health risk survey at least annually, to determine

areas where lifestyle modifications might reduce the risk of future disease and improve health outcomes and quality of life.

Counseling on Healthy Lifestyle Choices

- All individuals should be advised not to smoke or to use tobacco products, and to avoid exposure to second-hand smoke as much as possible. Those who use tobacco products should be advised to quit and assessed for their readiness to do so at each encounter.
- Individuals should be counseled on healthy eating patterns and offered access to relevant information.
- Individuals should be advised to limit their salt intake.
- Individuals should be advised to engage in at least 30 minutes of physical activity or resistance training, tailored to their individual health condition and risks, at least 3 days per week, with no more than 2 consecutive inactive days. More frequent and longer duration (e.g., 60 minutes/day) activity is better.
- See the following section details on why and how to achieve some of these goals.

Diet and Nutrition

There is strong evidence that nutrition plays an important role in our risk of disease. Dietary patterns that emphasize a lower percentage of total calories from fat, reduced amounts of saturated fats, and reduced sodium intake while achieving and maintaining a healthy body weight, have been shown to reduce the risk of cardiovascular disease, the most common cause of death in both men and women in the United States. No single diet has been shown to be the best, and providers should counsel individuals on a variety of healthy eating patterns tailored to their particular health condition and cultural background, while preserving the pleasure of meals and eating.

Healthy Dietary Patterns

Two dietary patterns that have been shown to improve some measures of cardiovascular risk are the Dietary Approaches to Stop Hypertension (DASH) and Mediterranean (MED) diets. Both dietary patterns emphasize reduced saturated fat and red meat; and increased fiber, vegetables, fruits, fish, oils, and nuts, while allowing wide freedom of food choices to accommodate eating preferences and

cultural differences among individuals.

The MED diet emphasizes:

- Increased servings of fruits (particularly fresh fruits), vegetables (particularly green and root vegetables), whole grains (such as whole-grain breads, rice, pasta, and cereals), and fatty fish (which are rich in omega-3 fatty acids);
- Reduced amounts of red meat (emphasizing lean meats when meat is eaten);
- Substituting lower fat or fat-free dairy products for higher fat options; and
- Using oils (such as olive or canola), nuts (such as walnuts, almonds, or hazelnuts), or margarines containing flaxseed or rapeseed oil, in place of butter and other saturated fats.

The DASH diet is:

- High in vegetables, fruits, low-fat or fat-free dairy products, whole grains, poultry, fish, legumes, and nuts; and
- Low in sweets, sugar-sweetened beverages, and red meats; and
- Lower in total fat and saturated fat than a typical American diet.

Dietary counseling on healthy eating patterns, such as those described above, provided as a routine part of an individual encounter, has been shown to reduce blood pressure in those with type 2 diabetes or risk factors for cardiovascular disease, including those with mild untreated hypertension. For individuals with normal or modestly elevated cholesterol, regardless of gender or ethnicity, following a DASH dietary pattern can reduce low-density-lipoprotein cholesterol (LDL-cholesterol) and high-density-lipoprotein cholesterol (HDL-cholesterol). Following a DASH dietary pattern can reduce blood pressure in all individuals, regardless of age, sex, and ethnicity, including those with mild untreated hypertension.

Salt Intake

There is strong evidence that reducing sodium (salt) intake reduces blood pressure in individuals with normal blood pressure as well as those with mild to moderate hypertension, regardless of sex, ethnicity, and age. This holds true even if no other dietary changes are made. Therefore, some individuals who consider the dietary patterns described above too drastic a change can reduce their blood pressure just

by lowering their salt intake. Those who adopt a DASH dietary pattern and reduce their salt intake can lower their blood pressure even more. All individuals should receive advice to limit their salt intake and be counseled on ways to do so.

Cholesterol

In spite of much public attention given to cholesterol in the diet as a cause of poor health, there has been very little research on the effect of reducing dietary cholesterol on the risk of future disease; therefore, no recommendation can be made to counsel individuals on dietary cholesterol intake specifically.

Physical Activity

Regular aerobic physical activity (e.g., walking, jogging, dancing, swimming, water-walking, gardening, climbing stairs, even house cleaning) and resistance training (e.g., working with light weights or elastic bands) can reduce the risk of serious disease by lowering LDL-cholesterol and blood pressure. Individuals should be encouraged to engage in at least 30 minutes of an activity they enjoy, suitable to their current health status and risk, at least 3 times a week, with no more than two consecutive inactive days. More intensive physical activity (e.g., up to 60 minutes at a setting, more sessions per week), for those whose health status permits, offer more benefit.

Reference

National Heart, Lung, and Blood Institute. Lifestyle interventions to reduce cardiovascular risk: Systematic Evidence Review from the Lifestyle Work Group (2013). Available at <http://www.nhlbi.nih.gov/health-pro/guidelines/in-develop/cardiovascular-risk-reduction/lifestyle>

Information for Patients and Educators

American Heart Association. Healthy Eating. Provides information on food choices, recipes, how to eat healthy when dining out, and how to shop for groceries with a focus on healthy eating. Available at http://www.heart.org/HEARTORG/HealthyLiving/HealthyEating/HealthyEating_UCM_001188_SubHomePage.jsp

American Heart Association. Get moving! Easy tips to get active. Provides information on physical activity and fitness. Available at http://www.heart.org/HEARTORG/HealthyLiving/PhysicalActivity/Physical-Activity_UCM_001080_SubHomePage.jsp

American Heart Association. Sodium and Salt. Provides information on ways to reduce dietary salt intake. Available at http://www.heart.org/HEARTORG/HealthyLiving/HealthyEating/Nutrition/Sodium-and-Salt_UCM_303290_Article.jsp#.WThZ4-v1DRY

Mayo Clinic. Healthy diets. Available at <http://www.mayoclinic.org/healthy-lifestyle/nutrition-and-healthy-eating/basics/healthy-diets/hlv-20049477>

Mayo Clinic. DASH diet: Healthy eating to lower your blood pressure. Available at <http://www.mayoclinic.org/healthy-lifestyle/nutrition-and-healthy-eating/in-depth/dash-diet/art-20048456>

Mayo Clinic. DASH diet recipes. Available at <http://www.mayoclinic.org/healthy-lifestyle/recipes/dash-diet-recipes/rcs-20077146>

Mayo Clinic. Mediterranean diet recipes. Available at <http://www.mayoclinic.org/healthy-lifestyle/nutrition-and-healthy-eating/in-depth/mediterranean-diet-recipes/art-20046682>

DIABETES MELLITUS SCREENING

Who Should Be Screened for Diabetes

The criteria below apply to non-pregnant patients only.

- Begin screening all adults at 45 years of age.
- Screen adults < 45 years of age who are overweight or obese ($\text{BMI} \geq 25$ kg/m^2 [$\text{BMI} \geq 23$ kg/m^2 for Asian Americans]) with 1 or more risk factor. An

[adult BMI calculator](#) is available from the Centers for Disease Control and Prevention (CDC).

- Screen overweight or obese children or adolescents (19 years of age or younger) with 2 or more additional risk factors. To determine whether the individual is overweight or obese, see the CDC web page [Defining Childhood Obesity](#) and the [child and teen BMI calculator](#) provided by the CDC.
- If screening test results are normal, retest at least every 3 years. Consider more frequent testing in patients with risk factors.
- *Patients with prediabetes (IFG or IGT) should be retested every year.
 - IFG and IGT refer to laboratory values that are above the normal range but do not meet the diagnostic criteria for diabetes. Persons with these results are said to have "prediabetes."
- All women with a diagnosis of gestational diabetes in a recent pregnancy should have diabetes screening with a 2-hour oral glucose tolerance test at 6-12 weeks postpartum, regardless of other risk factors.
- All women with any history of gestational diabetes should have testing for diabetes and prediabetes at least every 3 years, regardless of other risk factors.

Risk Factors for Diabetes

- High-risk race or ethnicity (e.g., Latino, African American, Asian American, Native American, Pacific Islander);
- Diabetes in a first-degree relative;
- Physical inactivity;
- Women who ever had gestational diabetes or delivered a baby weighing > 9 pounds;
- *History of prediabetes: hemoglobin A1C > 5.7% (39 mmol/mol), impaired fasting glucose (IFG), or impaired glucose tolerance (IGT) in previous testing;
- HDL cholesterol < 35 mg/dL (0.90 mmol/L) and/or serum triglyceride level > 250 mg/dL (2.82 mmol/L);
- A history of polycystic ovary syndrome;
- A diagnosis of hypertension;
- A history of cardiovascular disease; or
- Any other condition in which insulin resistance is common, such as severe obesity or acanthosis nigricans.

Diagnostic Criteria

Any one or more of the following results, confirmed on repeat testing, meets the criteria for a diagnosis of diabetes (repeat testing for confirmation is not required in the presence of unequivocal clinical hyperglycemia):

- Fasting plasma glucose (after no caloric intake for a minimum of 8 hours) \geq 126 mg/dL (7.0 mmol/L);
- Oral glucose tolerance test (OGTT) with a 2-hour postprandial glucose level \geq 200 mg/dL (11.1 mmol/L) following a 75-g glucose load;
- Hemoglobin A1C \geq 6.5% (48 mmol/mol) (For diagnosis of type I diabetes in individuals with acute hyperglycemic symptoms, blood glucose testing is preferred.); or
- Random plasma glucose \geq 200 mg/dL (11.1 mmol/L) in the setting of a hyperglycemic crisis or classic symptoms of hyperglycemia. (Confirmation by repeat testing is not required in this setting.)

Test	Criteria to Diagnose Diabetes Mellitus	Comments
Fasting plasma glucose	\geq 126 mg/dL (7.0 mmol/L)	After no caloric intake for a minimum of 8 hours
Oral glucose tolerance test (with a 75-g glucose load)	2-hour glucose \geq 200 mg/dL (11.1 mmol/L)	
Hemoglobin A1C	\geq 6.5% (48 mmol/mol)	For diagnosis of type I diabetes in individuals with acute hyperglycemic symptoms, blood glucose testing is preferred

Random plasma glucose	>/= 200 mg/dL (11.1. mmol/L)	If this occurs in the setting of a hyperglycemic crisis or classic symptoms of hyperglycemia, confirmation by repeat testing is not required
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Table: Diagnostic Criteria for Diabetes Mellitus. All initial results should be confirmed with repeat testing.

References

American College of Obstetricians and Gynecologists (2013). Practice Bulletin No. 137: Gestational diabetes mellitus. *Obstet Gynecol.* 122 406-416.

American Diabetes Association. Standards of medical care in diabetes – 2018. *Diabetes Care* (2018); 41(Suppl. 1). Available at http://care.diabetesjournals.org/content/41/Supplement_1

Resources for Patients and Educators

American Diabetes Association home page: <http://www.diabetes.org>

American Diabetes Association DiabetesPro website (information for providers of care) <http://professional.diabetes.org>

American Diabetes Association Diabetes Educators (information and resources for both patients and educators) <http://professional.diabetes.org/diabetes-education>

Centers for Disease Control and Prevention. Adult BMI calculator. Available at http://www.cdc.gov/healthyweight/assessing/bmi/adult_bmi/english_bmi_calculator/bmi_calculator.html

Centers for Disease Control and Prevention. BMI calculator for child and teen. Available at <http://nccd.cdc.gov/dnpabmi/Calculator.aspx>

Centers for Disease Control and Prevention. Defining childhood obesity web page (provides definition of overweight and obesity in children and adolescents 2 to 19 years of age, and link to BMI calculator for children and teens). Available at <http://www.cdc.gov/obesity/childhood/defining.html>

National Diabetes Education Initiative (patient education handouts and links to professional resources): <http://www.ndei.org>

National Institute of Diabetes and Digestive Diseases. National Diabetes Education Program (resources for patients and educators). Available at <http://www.niddk.nih.gov/health-information/health-communication-programs/ndep/pages/index.aspx>

National Heart, Lung, and Blood Institute Aim for a Healthy Weight website: https://www.nhlbi.nih.gov/health/educational/lose_wt

HYPERTENSION SCREENING

All individuals, including those with hypertension, should be advised to adhere to a healthy lifestyle as described in the Healthy Lifestyle Intervention section of this clinical policy manual.

Classification of BP and diagnosis of hypertension:

In the United States, high blood pressure (BP) is the second leading cause of preventable death after cigarette smoking and is the most important modifiable risk factor for death due to cardiovascular disease. Because hypertension is generally asymptomatic, it is important that all persons be screened at least annually for elevated BP.

The following table provides guidance on diagnosis of hypertension in adults. Recent guidelines emphasize greater reliance on home BP monitoring to aid in the diagnosis of hypertension when clinic readings are high normal, borderline high, or elevated. It is generally agreed that clinic BP measurements are often higher than home BP measurements, particularly in the higher ranges of BP.

BP (mm Hg)	Category
< 120/80	Normal
120-129/<80	Elevated
130-139/80-89	Stage 1 hypertension
>/= 140/90	Stage 2 hypertension

Measurement of blood pressure:

- For diagnosis of hypertension, BP readings should be based on the average of accurate measurements taken on 2 or more occasions using proper technique.
- Ambulatory or home BP monitoring should be performed to confirm the diagnosis of hypertension.
- Adults not being treated for hypertension who have office BP readings of 130/80 to 160/100 mm Hg should be screened for white coat hypertension (WCH, high BP in the clinic but normal BP outside the clinic) using ambulatory or home BP monitoring.
- Periodically monitor adults with WCH using ambulatory or home BP monitoring to assess for development of sustained hypertension.
- Adults not being treated for hypertension who have office BP readings of 120/75 to 129/79 mm Hg consistently should be screened for masked hypertension (normal BP in the clinic but high BP outside the clinic) using ambulatory or home BP monitoring.

Instructions for home BP monitoring:

- Patients should receive instruction for home BP monitoring, including interpretation of results, under medical supervision.
- An automated validated device should be used, preferably with the ability to store readings in memory.
- Correct cuff size should be verified, and the patient should be instructed to measure BP in the arm with the higher reading if a significant difference is observed between arms.
- Instruct the patient to rest quietly for at least 5 minutes, and avoid exercise, caffeine, and smoking for at least 30 minutes before taking BP.
- Instruct the patient to sit upright in a straight-backed chair with feet flat on the floor, legs uncrossed, and the arm supported on a flat surface with the upper arm at heart level.
- The bottom of the cuff should sit directly above the antecubital fossa.
- Two readings, taken 1 minute apart, should be done twice daily, in the morning before taking any medications, and in the evening before eating supper. Measurements should be done daily, for one week before a clinic visit.
- Monitors with stored memory should be brought to any clinic appointments.
- Clinical decision making should be based on the average of readings taken on 2 or more occasions.

Nonpharmacologic intervention:

All patients, regardless of BP category should receive instruction in healthy lifestyle habits, with regular reinforcement of teaching.

- Weight loss should be advised for adults who are overweight or obese.
- Persons with elevated BP or hypertension should adopt a heart-healthy diet (e.g., DASH diet) to reduce BP.
- Sodium intake should be reduced.
- Potassium intake should be increased, preferably by dietary modification.
- Physical activity should be increased using a structured exercise program.
- Alcohol intake should be avoided or moderated (\leq 1 standard drink daily for women, \leq 2 standard drinks daily for men).

References

Carey, R. M., Whelton, P. K. (2018). Prevention, detection, evaluation, and management of high blood pressure in adults: Synopsis of the 2017 American College of Cardiology/American Heart Association hypertension guideline. *Ann Intern Med*, 168(5), 351-358. Available at <http://annals.org/aim/fullarticle/2670318/prevention-detection-evaluation-management-high-blood-pressure-adults-synopsis-2017>

Whelton, P. K., Carey, R. M., Aronow, W. S., Casey, D. E., Collins, K. J., Himmelfarb, C. D., Wright, J. T. (2017). ACC/AHA/AAPA/ABC/ACPM/AGS/APha/ASH/ASPC/NMA/PCNA Guideline for the prevention, detection, evaluation, and management of high blood pressure in adults. *Hypertension*, 71(6), e13-e115. Available at <http://hyper.ahajournals.org/content/71/6/e13.long>

Whelton, P. K., Carey, R. M., Aronow, W. S., Casey, D. E., Collins, K. J., Himmelfarb, C. D.,...Wright, J. T. (2017). 2017 ACC/AHA/AAPA/ABC/ACPM/AGS/APha/ASH/ASPC/NMA/PCNA Guideline for the prevention, detection, evaluation, and management of high blood pressure in adults: Executive Summary: A report of the American College of Cardiology/American Heart Association task force on clinical practice guidelines. *J Am Coll Cardiol*, 71(19), 2199-2269. Available at <https://www.sciencedirect.com/science/article/pii/S073510971741518X?via%3Dihub>

Resources for Patients and Educators

American Heart Association. High blood pressure. Provides information on the meaning and importance of high blood pressure, risks for and prevention of high

blood pressure, blood pressure monitoring, and treatment of high blood pressure. Available at http://www.heart.org/HEARTORG/Conditions/HighBloodPressure/High-Blood-Pressure_UCM_002020_SubHomePage.jsp

National Heart, Lung, and Blood Institute. Description of high blood pressure. Provides a plain-language discussion of the prevention, diagnosis, and treatment high blood pressure. Available at <http://www.nhlbi.nih.gov/health/health-topics/topics/hbp>

Resources for Providers

American Society of Hypertension. Hypertension Guidelines website: <http://www.ash-us.org/About-Hypertension/Hypertension-Guidelines.aspx>

SCREENING FOR HIGH CHOLESTEROL

Note that the summary of cited guideline recommendations provided in this section reflect the ages of eligibility for the FPP, and do not include guideline recommendations for individuals outside this eligibility range.

The diagnosis and treatment of elevated blood cholesterol is a complex subject and a complete discussion is beyond the scope of this clinical policy manual. For more information, providers are referred to the reference section below and relevant textbooks.

Rationale for Cholesterol Screening

Evidence shows that a healthy lifestyle (following a heart healthy diet, maintaining a healthy weight, regular exercise, and avoidance of tobacco products) reduces the risk of cardiovascular disease. In certain persons with specific risk factors, cholesterol-lowering medications (i.e., statins) can further reduce the risk of an adverse health event. Measurement of blood cholesterol is a component of the individual risk assessment in some patients.

Who Should Be Screened for High Cholesterol

- All men 35 years of age and older;
- Men 20-35 years of age with increased risk for coronary heart disease;
- Women 20 years of age and older with increased risk for coronary heart disease (CHD);
- No recommendation is made regarding routine screening in men 20-35 years of age, or in women 20 years of age or older without increased risk of CHD.

Risk Factors

Increased risk of CHD is defined by the presence of any 1 of the risk factors below. Greater risk results from the presence of multiple risk factors.

- Diabetes;
- Personal history of previous CHD or non-coronary atherosclerosis;
- Family history of cardiovascular disease in men before age 50 and in women before age 60;
- Tobacco Use;
- Hypertension; or
- Obesity (body mass index ≥ 30 kg/m²).

Screening Frequency

The optimal interval for screening is uncertain. Reasonable options include every 5 years, shorter intervals for people who have lipid levels close to those warranting therapy, and longer intervals for those not at increased risk who have had repeatedly normal lipid levels.

An age at which to stop screening has not been established.

Screening Method

The preferred screening test for elevated cholesterol is the serum lipid panel (total cholesterol, high-density lipoprotein [HDL] cholesterol, and low-density lipoprotein [LDL] cholesterol) in the fasting or non-fasting state. If non-fasting results are

used, only the total cholesterol and HDL-cholesterol are reliable. Abnormal screening results should be confirmed by a repeat sample on a separate occasion, and the average of both results should be used for risk assessment.

Evaluation of Screening Results

Results of the lipid profile should be interpreted in the context of the individual's risk factors and 10-year estimated risk of atherosclerotic cardiovascular disease (ASCVD; defined as acute coronary syndrome, myocardial infarction, stable or unstable angina, stroke, transient ischemic attack, coronary or other arterial revascularization procedure, or atherosclerotic peripheral arterial disease). A [risk calculator](#) for 10-year ASCVD risk is available from the American College of Cardiology and American Heart Association.

Studies have shown a benefit of statin therapy in individuals with the following risk profiles:

- All individuals with clinical ASCVD, regardless of lipid profile results;
- Any individuals with LDL-cholesterol ≥ 190 mg/dL;
- Individuals 40 years of age or older with diabetes and LDL-cholesterol ≥ 70 -189 mg/dL and no clinical ASCVD;
- Individuals 40 years of age or older with diabetes and LDL-cholesterol 70-189 mg/dL and no clinical ASCVD; or
- Individuals of any age without diabetes or clinical ASCVD, with LDL-cholesterol 70-189 mg/dL and 10-year ASCVD risk $\geq 7.5\%$.

References

Stone NJ, et al. 2013 ACC/AHA Guidelines on the Treatment of Blood Cholesterol to Reduce Atherosclerotic Cardiovascular Risk in Adults. *Circulation* (2014). 129(25 Suppl 2): S1-S45 Available at <https://circ.ahajournals.org/content/early/2013/11/11/01.cir.0000437738.63853.7a.full>

National Heart, Lung, and Blood Institute. Third Report of the National Cholesterol Education Program (NCEP) Expert Panel on Detection, Evaluation, and Treatment of

High Cholesterol in Adults (Adult Treatment Panel III). NIH Publication No. 01-3670, May 2001. Available at <http://www.nhlbi.nih.gov/files/docs/guidelines/atp3xsum.pdf>

U.S. Preventive Services Task Force. The Guide to Clinical Preventive Services, "Lipid Disorders in Adults" (2014). Page 45. Available at <http://www.ahrq.gov/sites/default/files/publications/files/cpsguide.pdf>

Further Reading

Pursnani A, et al. Guideline-based statin eligibility, coronary artery calcification, and cardiovascular events. *JAMA* (2015) 314:134-141 Available at <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC4754085/>

Resources for Providers

ASCVD Risk Estimator from the American College of Cardiology. Provides an estimate of the 10-year risk of developing ASCVD. Available at <http://tools.acc.org/ASCVD-Risk-Estimator/>

POSTPARTUM DEPRESSION SCREENING

Prevalence and Risk Factors for Postpartum Depression

As many as 80% of new mothers experience a brief episode of the "baby blues" which may last up to about 2 weeks. Approximately 5-25% of new mothers will experience postpartum depression that warrants intervention. It typically begins in the first 4 to 6 weeks after birth of the infant, but may develop any time in the first year.

Risk factors for postpartum depression include all of the following:

- Lack of social support;
- Symptoms of depression (especially in the third trimester) or anxiety during the pregnancy;

- Prior psychiatric illness or poor mental health, especially prior postpartum depression;
- Family history of depression, anxiety, or bipolar disorder;
- Low socio-economic status or low educational level;
- Poor income or unemployment;
- Poor relationship with the partner or father of the baby;
- A negative attitude toward the pregnancy;
- A recent stressful life event or perceived stress;
- Intention to return to work;
- A history of bothersome premenstrual syndrome;
- A history of physical, sexual, or psychological abuse; domestic violence;
- Stress related to child care issues;
- Medical illness or prematurity in the infant;
- A temperamentally difficult infant; or
- Immigrant from another country.

Common signs and symptoms of postpartum depression include the following (note that some or none of these symptoms may be apparent):

- Difficulty sleeping even when the baby is sleeping;
- Tearfulness, prone to crying;
- Excessive worrying about the baby;
- Excessive anxiety;
- Feelings of guilt, such as the feeling that she is not a good mother;
- Flat affect; or
- Poor appetite.

Screening for Postpartum Depression

Providers are encouraged to review [The Texas Clinician's Postpartum Depression Toolkit](#) for a more detailed review of screening for postpartum depression.

Because postpartum depression can be a serious, and sometimes life-threatening condition, all new mothers should have screening for postpartum depression at the postpartum visit. For those who screen negative, repeat screening should be considered at a later visit or when the mother takes her baby in for a checkup.

A standardized self-administered screening tool with review and follow-up questions in a face-to-face interview with the provider will ensure consistency and efficiency in the screening process. The following postpartum depression screening tools are available on-line, and have been validated for use in postpartum patients:

- [Edinburgh Postnatal Depression Scale](#) (EPDS; Cox, Holden, & Sagovsky, 1987)
- [Patient Health Questionnaire-9](#) (PHQ-9; Spitzer, Kroenke, & Williams, 1999)
- Postpartum Depression Screening Scale (PDSS; Beck & Gable, 2001)

To ensure that all patients are screened without undue interruption of clinic workflow, a convenient approach to screening is the following:

- Give each postpartum woman a screening tool to complete while she waits for her visit with the provider.
- Score the tool and assess whether the screen is positive or negative:
 - EPDS: A score of 10 or more suggests depressive symptoms, a score of 13 or more indicates a high likelihood of major depression; a score of 1 or more on question #10 is an automatic positive screen because it indicates possible suicidal ideation and should be addressed appropriately.
 - PHQ-9: A score of 10 or more indicates a high risk of having or developing depression; a score of 2 or more on question #9 is an automatic positive screen because it indicates possible suicidal ideation and should be addressed appropriately.
 - PDSS Full form: A score of 60 or more suggests depressive symptoms, a score of 81 or more indicates a high likelihood of major depression; a score of 6 or more on the SUI (suicidal thoughts) subscale is an automatic positive screen because it indicates possible suicidal ideation and should be addressed appropriately.

- PDSS Short form: A score of 14 or more indicates a high risk of major depression; a score of 2 or more on question #7 is an automatic positive screen because it indicates possible suicidal ideation and should be addressed appropriately.
- The provider should review the screen and discuss it with the woman and ask follow-up questions to evaluate her risk of postpartum depression.

SCREENING FOR SUICIDE RISK

Any individual with a positive screen based on responses to questions related to suicide risk, and any individual who expresses suicidal thoughts or ideation must be evaluated immediately for suicide risk. If the individual is felt to be acutely at risk of suicide, she must be referred for emergent evaluation and/or hospitalization as indicated.

REFERRAL FOR TREATMENT

Individuals in need of treatment for postpartum depression should be referred to a provider of behavioral health services. Providers must have arrangements in place for appropriate referral of individuals to behavioral health providers in their area. For information on local behavioral health care providers, refer to the website of the [Office of Mental Health Coordination](#), Texas Health and Human Services, or call 211.

Coding for postpartum depression services

The following Current Procedural Terminology (CPT) codes are covered under the Family Planning program:

99201	99202	99203	99204	99205
99211	99212	99213	99214	99215
90791	90792			

References

American College of Obstetricians and Gynecologists Committee Opinion no. 630. Screening for perinatal depression. *Obstet Gynecol* (2015). 125: 1268-1271. Available at <http://www.acog.org/Resources-And-Publications/Committee-Opinions/Committee-on-Obstetric-Practice/Screening-for-Perinatal-Depression>

Hirst KP and Moutier CY. Postpartum major depression. *American Family Physician* (2010). 82: 926-933. Available at <http://www.aafp.org/afp/2010/1015/p926.html>

Norhayati MN, et al. Magnitude and risk factors for postpartum symptoms: A literature review. *J Affect Disord* (2015). 175: 34-52.

O'Connor E, et al. Primary care screening for and treatment of depression in pregnant and postpartum women: Evidence report and systematic review for the US Preventive Services Task Force. *JAMA* (2016). 315: 388-406.

Resources for Patients and Providers

American Academy of Family Physicians. Postpartum Depression web page. Information for patients and providers on postpartum depression. Available at <http://familydoctor.org/familydoctor/en/diseases-conditions/postpartum-depression.html>

American Academy of Family Physicians. Postpartum Depression Action Plan. Available at <http://familydoctor.org/familydoctor/en/diseases-conditions/postpartum-depression/treatment/postpartum-depression-action-plan.html>

Office of Mental Health Coordination website, Texas Health and Human Services, provides links to information for providers and patients in Texas on a variety of behavioral health topics, and a link to the Substance Abuse and Mental Health Services Administration (SAMHSA) behavioral health treatment services locator. Available at <http://mentalhealthtx.org/>

STEP-PPD Support and training to enhance primary care for postpartum depression website. Provides links to resources, including postpartum depression screening tools, online training, case studies, classroom materials, "Clinician's Pocket Guide," and other materials. Available at <https://step-ppd.com/>

Texas Health and Human Services. The Texas Clinician's Postpartum Depression Toolkit. Contains a review of the diagnosis and treatment of postpartum depression for the primary care provider, including a section on covered services, coding, and billing for services provided under Texas state healthcare programs. Available at <https://www.healthytexaswomen.org/provider-resources#family-planning-program>

PERINATAL CLINICAL POLICY

Prenatal services should be provided based on ACOG guidelines.

COMPONENTS OF INITIAL PRENATAL INTERVENTIONS/SCREENING

Prenatal Visit – The initial encounter with a pregnant woman includes:

Complete history, physical examination, assessment, planning, treatment, counseling and education, referral as indicated, routine prenatal laboratory tests and additional laboratory tests as indicated by history, physical exam and/or assessment.

COMPONENTS OF RETURN VISIT INTERVENTIONS/SCREENING

Return Prenatal Visit - Follow up prenatal visit includes interval history, physical examination, risk assessment, medical services, nutritional counseling, psychosocial counseling, family planning counseling, and client education regarding maternal and child health topics. Hemoglobin and/or hematocrit, and urinalysis for protein and glucose are also included.

PERINATAL HISTORIES

Prenatal Visit

The comprehensive medical history documented at the initial prenatal visit must at least address the following:

- current health status, including acute and chronic medical conditions, if any;
- significant past illnesses, including hospitalizations;
- previous surgeries and biopsies;
- blood transfusions and other exposure to blood products;
- mental health history (e.g., depression, anxiety);
- current medications, including prescription, over the counter (OTC) as well as complementary and alternative medicines (CAM);
- allergies, sensitivities or reactions to medicines and other substances (e.g. latex, seafood);
- immunization status/assessment, including rubella status;
- reproductive health history, including
- pertinent sexual behavior history, including family planning practices (i.e., past contraceptive use), number of partners, gender of sexual partners;
- sexually Transmitted Infections (STIs) (including hepatitis B and C), and HIV history, risks, and exposure;
- pertinent partner history, including injectable drug use, number of partners;
- menstrual history, including last normal menstrual period;
 - o obstetrical history, detailed;
 - o gynecological and urological conditions;
 - o cervical cancer screening history (date and results of last Pap test or other cervical cancer screening test, note any abnormal results and treatment); and
 - o social history/health risk assessment (HRA), including:
 - o home environment, to include living arrangements;
 - o family dynamics with assessment for family violence (including safety assessment, when indicated) (Mandated by Texas Family Code, Chapter 261 and Rider 19);
 - o tobacco/alcohol/recreational drug use/abuse and/or exposure;
 - o drug dependency (including type, duration, frequency, route);
 - o nutritional history;
 - o occupational hazards or environmental toxin exposure;

- o ability to perform activities of daily living (ADLs);
- o risk assessment including, but not limited to:
 - diabetes;
 - heart disease;
 - intimate partner violence;
 - other physical or sexual abuse;
 - human trafficking;
 - injury;
 - malignancy;
 - injury;
 - malignancy;
- family history, including genetic conditions;
 - o review of systems with pertinent positives and negatives documented in health record.

Return Prenatal Visits

Interval history includes:

- symptoms of infections;
- symptoms of preterm labor;
- headaches or visual changes;
- fetal movement (>18 weeks); and
- family violence screening (repeat >28 weeks).

PHYSICAL ASSESSMENTS

All initial and routine prenatal visits must include an appropriate physical exam according to the purpose of visit and week of gestation. For any portion of the examination that is deferred, the reason(s) for deferral must be documented in the client health record.

Initial Prenatal Visit

- height measurement;
- weight measurement, with documentation of pre-pregnancy weight and assessment for underweight, overweight, and obesity;
- body mass index (BMI);
- blood pressure evaluation;
- cardiovascular assessment;
- clinical breast exam;
- visual inspection of external genitalia and perianal area;
- pelvic exam, including estimate of uterine size (by bimanual exam for gestational age less than or equal to 14 weeks or by fundal height for gestational age equal to or more than 14 weeks);
- fetal heart rate for gestational age > 12 weeks; and
- other systems as indicated by history and health risk assessment. (e.g., evaluation of thyroid, lungs, abdomen).

Return Prenatal Visits

- weight measurement;
- blood pressure evaluation;
- uterine size/fundal height;
- fetal heart rate (> 12 weeks);
- fetal lie/position (> 30 weeks); and
- other systems as indicated by history or other findings.

LABORATORY AND DIAGNOSTIC TESTS

All initial and return prenatal visits must include appropriate laboratory and diagnostic tests as indicated by weeks of gestation and clinical assessment. Contractors must have written plans to address laboratory and other diagnostic test orders, results and follow-up to include:

- tracking and documentation of tests ordered and performed for each patient;
- tracking of test results and documentation in patient records; and
- mechanism to address abnormal results, facilitate continuity of care and assure confidentiality, adhering to HIPAA regulations (i.e., making results and interventions accessible to the delivering hospital, facility or provider).

Initial Prenatal Visit Laboratory and Diagnostic Tests

- blood type, Rh and antibody screen;
- sexually transmitted infection testing as indicated by risk assessment, history, and physical exam, and the following:
 - o chlamydia and gonorrhea testing should be done on all patients age 25 or younger, and older individuals at increased risk of infection, even if symptoms are not present;
 - o Hepatitis B Antigen (HbsAg) (Mandated by Health and Safety Code 81.090);
 - o HIV, unless declined by the person, who must then be referred to anonymous testing (Mandated by Health and Safety Code 81.090);

Review CDC's revised [recommendations for HIV testing](#) for adults and pregnant women.

- o syphilis serology (Mandated by Health and Safety Code 81.090);
- hemoglobin and/or hematocrit;
- rubella serology, or positive immune status /immunization documented in chart;
- cervical cancer screening test (e.g., Pap test) for women 21 years and older, if indicated;
- hemoglobinopathy screening, as indicated;
- urine culture;
- TB skin test as indicated by risk assessment, history, or physical exam (see the Heartland National TB Center algorithm for pregnant individuals http://www.heartlandntbc.org/assets/products/evaluation_of_pregnant_patient_at_risk_for_tb.pdf .);
- ultrasound, as clinically indicated; and

- other laboratory and diagnostic tests as indicated by risk assessment, history and physical exam.

ACOG/ACS/ASCCP/ASCP Cervical Cancer Screening Guidelines

- Cervical cancer screening begins at age 21 years;
- Cervical cytology (Pap smear) alone, with reflex human papillomavirus (HPV) testing when cytology reveals atypical squamous cells of undetermined significance (ASCUS), every three (3) years for women between the ages of 21 and 29 years;
- Women 30 years of age and older should have co-testing with cervical cytology and HPV testing every 5 years (prefer-ed), or cervical cytology testing alone (with reflex HPV testing for ASCUS) every 3 years.
- Both liquid-based and conventional methods of cervical cytology are acceptable for screening.

Women with special circumstances, who are considered high-risk (e.g. HIV+, immunosuppressed or were exposed to Diethylstilbestrol (DES) in utero) may be screened more frequently as determined by the clinician.

Individuals already following a plan of care/algorithm may continue with that plan of care/algorithm until completed and they return to routine screening. Once the person returns to routine screening follow the guidelines above.

Return Prenatal Visits Laboratory and Diagnostic Tests

- Fetal aneuploidy screening appropriate for the gestational age at the time of testing should be offered to all patients with appropriate counseling;
- diabetes screen (24 – 28 weeks);
- Glucose Tolerance test (GTT) for abnormal diabetic screen;
- antibody screen for Rh negative individuals, not previously known to be sensitized, between 24 – 28 weeks (if negative, repeat Anti-D immune globulin at ~28 weeks; if positive, refer to specialist in high-risk obstetrics for evaluation of possible maternal Rh-D alloimmunization);
- hemoglobin and/or hematocrit (recommended recheck between 32 – 36 weeks);

- group B streptococcus screen, between 35 – 37 weeks if using screened-based approach [see the Centers for Disease Control and Prevention (CDC) revised 2002 recommendations to prevent perinatal transmission of Group B Streptococcus (GBS) infection to the neonate on the CDC web site at <http://www.cdc.gov/mmwr/preview/mmwrhtml/rr5111a1.htm>];
- ultrasound, as clinically indicated;
- non-stress test (NST) to assess fetal well-being, as clinically indicated;
- biophysical profile (BPP)/fetal biophysical profile (FBPP) to assess fetal wellbeing, as clinically indicated; and
- other laboratory and diagnostic as indicated by risk assessment, history and physical exam.

DIAGNOSTIC TESTS AND INTERVENTIONS

Ultrasounds

Obstetrical ultrasounds will be reimbursed when clinically indicated, including the following:

- estimation of gestational age for women with uncertain clinical dates;
- verification of dates for women who had a previous cesarean delivery;
- vaginal bleeding of undetermined origin;
- suspected multiple gestation;
- significant uterine size/clinical dates discrepancy;
- pelvic mass;
- suspected ectopic pregnancy;
- suspected fetal death;
- suspected uterine abnormality;
- intrauterine contraceptive device localization;
- abnormal alpha-fetoprotein value;
- follow-up observation of identified fetal anomaly;
- follow-up evaluation of placental location for suspected placenta previa;

- history of previous congenital anomaly;
- serial evaluation of fetal growth in multifetal gestation;
- evaluation of fetal condition in late registrants for prenatal care; and
- other conditions associated with possible adverse fetal outcome.

Complete ultrasound – A complete evaluation of the pregnant uterus, to include fetal number, viability, presentation, dating measurements, complete anatomical survey; placental localization characterizations, and amniotic fluid assessment.

Complete ultrasound for confirmed multiple gestation – A complete evaluation of the pregnant uterus that includes viability, presentation, dating measurements, complete anatomical survey, placental localization characterizations, and amniotic fluid assessment.

Follow-up or limited ultrasound – A brief, more limited evaluation of the pregnant uterus that may follow a previous complete exam, be it an initial exam prior to 12 weeks, or be it an initial exam 12 weeks which is limited in scope. It includes fetal number, viability, presentation, dating measurements, limited anatomic assessment; placental localization and characterization; and amniotic fluid assessment.

Repeat D-antibody test - For all unsensitized D-negative women at 24-28 weeks of gestation followed by the administration of a full dose of D immunoglobulin if they are antibody negative. If the father is known with certainty to be Rh D-negative, this may be deferred.

Special Procedures

Non-Stress Test (NST) fetal well-being assessment to be performed in the presence of identified risk factors, as indicated, once a viable gestational age has been reached. It may be billed as often as the provider deems the procedure to be medically necessary.

Biophysical Profile (BPP)/Fetal Biophysical Profile (FBPP) – fetal well-being assessment to be performed in the presence of identified risk factors, as indicated,

once a viable gestational age has been reached. It may be billed as often as the provider deems the procedure to be medically necessary.

EDUCATION AND COUNSELING SERVICES

Contractors must have written plans for individual education that ensure consistency and accuracy of information provided, and that identify mechanisms used to ensure client understanding of the information.

Education and counseling must be:

- documented in the client health record;
- appropriate to the person's age, level of knowledge and socio-cultural background;
- presented in an unbiased manner.

Education and counseling during the initial prenatal visit, based on health history, risk assessment and physical exam, must cover the following:

- nutrition and weight gain counseling;
- family and intimate partner violence/abuse;
- human trafficking;
- physical activity and exercise;
- sexual activity;
- environmental or work hazards;
- travel;
- tobacco cessation;
- alcohol use;
- substance abuse;
- breastfeeding;
- when and where to obtain emergency care;
- risk factors identified during visit;

- anticipated course of prenatal care;
- HIV and other prenatal tests;
- injury prevention, including seat belt use;
- cocooning infants/children against pertussis (immunization of family members and potential caregivers of infant);
- toxoplasmosis precautions;
- referral to WIC;
- use of medications (including prescription, over the counter (OTC), and complementary/alternative medicines (CAM));
- information on parenting and postpartum counseling (Mandated by Chapter 161, Health and Safety Code, Subchapter T); and
- other education and counseling as indicated by risk assessment, history and physical exam.

Education and counseling during the return prenatal visits, should be appropriate to weeks' gestation and be based on health history, risk assessment and physical exam, including, but not limited to:

- signs and symptoms of preterm labor beginning in 2nd trimester;
- signs and symptoms of labor as the patient nears term gestation;
- warning signs and symptoms of pregnancy induced hypertension (PIH);
- selecting provider for infant;
- postpartum family planning.

Tobacco Assessment and Quit Line Referral - All women receiving prenatal services should be assessed for tobacco use. Women who use tobacco should be referred to tobacco quit lines. The Texas American Cancer Society Quit Line is 1-877-YES-QUIT or 1-866-228-4327 (Hearing Impaired). The assessment and referral should be performed by agency staff and documented in the clinical record.

Information for Parents of Newborns Requirement: Chapter 161, Health and Safety Code, Subchapter T requires hospitals, birthing centers, physicians, nurse-midwives, and midwives who provide prenatal care to pregnant women during gestation or at delivery to provide the woman and the father of the infant or other adult caregiver for the infant with a resource pamphlet that includes information on postpartum depression, shaken baby syndrome, immunizations, newborn

screening, pertussis and sudden infant death syndrome. In addition, it must be documented in the person's chart that she received this information and the documentation must be retained for a minimum of five years. It is recommended that the information be given twice, once at the first prenatal visit and again after delivery.

Information for Parents of Children: Chapter 161, Health and Safety Code,

Subchapter T also requires hospitals, birthing centers, physicians, nurse-midwives, and midwives who provide prenatal care during gestation or at delivery to pregnant women on Medicaid to provide the woman and the father of the infant or other adult caregiver for the infant with a resource guide that includes information relating to the development, health, and safety of a child from birth until age five. The resource guide must provide information about medical home, dental care, effective parenting, child safety, importance of reading to a child, expected developmental milestones, health care and other resources available in the state, and selecting appropriate child care.

Provision of Information about Umbilical Cord Blood Donation

Requirement: Chapter 162, Health and Safety Code, Subtitle H requires that a physician or other person permitted by law to attend a pregnant woman during gestation or at delivery of an infant shall provide the woman with an informational brochure, before the third trimester of the woman's pregnancy or as soon as reasonably feasible, that includes information about the uses, risks and benefits of cord blood stem cells for a potential recipient, options for future use or storage of cord blood, the medical process used to collect cord blood, any costs that may be incurred by a pregnant woman who chooses to donate or store cord blood after delivery, and average cost of public and private storage. The brochure is available on the DSHS website or can be ordered from the DSHS literature warehouse.

[https://www.dshs.state.tx.us/pdf/umbilical_brochure_\(2\).pdf](https://www.dshs.state.tx.us/pdf/umbilical_brochure_(2).pdf)

Education and counseling during postpartum visits should include but not be limited to:

Physiologic changes;

- Signs and symptoms of common complications;
- Care of the breast;
- Care of perineum and abdominal incision, if indicated;
- Physical activity and exercise;

- Breastfeeding/Infant feeding;
- Resumption of sexual activity;
- Family planning/contraception;
- Preconception counseling; or
- Depression/postpartum depression

REFERRAL AND FOLLOW-UP

Agencies must have written policies and procedures for follow-up on referrals that are made as a result of abnormal physical examination or laboratory test findings. These policies must be sensitive to patients' concerns for confidentiality and privacy and must be in compliance with state or federal requirements for transfer of health information.

For services determined to be necessary, but which are beyond the scope of the agency, patients must be referred to other providers for care. (Whenever possible, patients should be given a choice of providers from which to select.) When a patient is referred to another provider or for emergency clinical care, the agency must:

- Make arrangements for the provision of pertinent individual information to the referral provider (obtaining required patient consent with appropriate safeguards to ensure confidentiality – i.e., adhering to HIPAA regulations)
- Advise individual about his/her responsibility in complying with the referral
- Counsel individual of the importance of the referral and follow-up method.

PROGRAM PROMOTION AND OUTREACH

Contractors must promote their Family Planning Program and provide outreach within the community to:

- inform the public of the purpose of the program and available services;
- disseminate basic family planning information;
- enlist community support; and
- attract potential individuals.

To help facilitate community awareness of and access to Family Planning Program services, contractors should establish and implement planned community activities to promote their programs.

Contractors should consider a variety of program promotion and outreach strategies in accordance with organizational capacity, availability of existing resources and materials, and the needs and culture of the local community. To gauge the efficacy of program promotion and outreach activities, contractors must:

- develop an annual Family Planning Program promotion and outreach plan;
- regularly monitor plan implementation;
- evaluate the plan on an annual basis; and
- modify program promotion and outreach activities, as needed.

Within forty-five days after the end of the contract period, contractors must submit a Family Planning Program Promotion/Outreach Annual Report to:
famplan@hhsc.state.tx.us.

MEDICAID PROVIDER ENROLLMENT

HHSC FPP contractors are required to enroll as Medicaid (Title XIX) providers with TMHP. The contractor must complete the required Medicaid provider enrollment application forms and enter into a written provider agreement with the HHSC, the single state Medicaid agency. TMHP Provider Enrollment supplies these forms.

Family planning agencies are not required to enroll as a Physician Group, which includes an application for Performing Provider number. To enroll as a family planning agency, all that is required is a supervisory practitioner. The supervisory practitioner may be a physician or nurse practitioner, and it may be the same person for all clinic sites. Changes in supervisory practitioner must be reported in writing to TMHP. An application must be submitted for the new supervisory practitioner.

When enrolling as a Title XIX provider, Clinical Laboratory Improvement Amendments (CLIA) information must be provided. For public health agencies that provide limited numbers of tests, one CLIA certificate is all that is required for all clinics.

Provider Identifiers

When a contractor's Medicaid application is approved, TMHP assigns the contractor a nine-digit Texas Provider Identifier (TPI). **Contractors must have a unique TPI for each clinical service site.**

Contractors must submit claims to TMHP using the billing TPI where clinical services are rendered. Contractors must not provide FPP services at one clinic site and bill those services to TMHP using the TPI of a different clinic site. If an additional TPI clinic site is required, providers must contact TMHP and complete the enrollment process.

The TPI is used in conjunction with a National Provider Identifier (NPI) to identify the provider for claims processing. An NPI is a 10-digit number assigned randomly by the National Plan and Provider Numeration System (NPPES). Contractors may apply for an NPI at the [NPPES](#) website.

When a provider obtains their NPI they are required to attest to NPI data for each of their current TPI. For more information on NPI and the attestation process please visit the [TMHP](#) website.

Texas Medicaid & Healthcare Partnership and Compass 21

HHSC FPP claims are submitted to TMHP. TMHP processes claims using Compass 21, an automated claims processing and reporting system. Claims are subject to the following procedures:

Claims are verified through a series of program edits and audits.

- Contractors receive an explanation of benefit (EOB) for each payment or denial. The EOBs are found on the Remittance and Status (R&S) report, which contractors may access electronically through the TMHP website. The report identifies paid, denied, or pending claims. If no claim activity or outstanding account receivable exists during the time period, the contractor will not receive an R&S for the week.

Texas Medicaid Provider & Procedures Manual

The *Texas Medicaid Provider & Procedure Manual* (TMPPM) includes information related to HHSC FPP claims submission such as:

- Funding sources;
- Claim billing instructions for family planning and third-party insurance;
- Sterilization consent form instructions;
- Use of the 2017 Claim Form;
- Filing deadlines;
- Claim appeals;
- FPP information;
- Diagnosis and procedure codes;
- Contraceptive devices and related procedures;
- Drugs and supplies;
- Medical counseling and education;
- Sterilization and sterilization-related procedures; and
- Additional filing resources.

In addition, Medicaid bulletins and R&S banner messages provide up-to-date claims filing and payment information. The R&S banner messages, and the TMPPM are all available on the [TMHP website](#).

REIMBURSEMENT FOR FAMILY PLANNING SERVICES

Family planning contractors may seek reimbursement for project costs using one or two methods.

- Contractors may submit monthly vouchers for expenses outlined in a categorical budget approved by HHSC, as required for the categorical cost reimbursement method, and/or
- Contractors may be reimbursed using the fee-for-service reimbursement method, by submitting claims to TMHP for services rendered.

Contractors may designate up to 50% of their total award on a categorical cost reimbursement basis. The remaining portion of their award will be paid on a fee-for-service basis. Contractors may designate up to 100% of their total award on a fee-for-services basis.

Categorical Reimbursement

The categorical portion of the HHSC FPP funding is used to develop and maintain contractor infrastructure for the provision of family planning services. The funding can be used to support clinic facilities, staff salaries, utilities, medical and office supplies, equipment, and travel, as well as direct medical services. Costs may be assessed against any of the following categories the contractor identifies during their budget development process:

- Personnel;
- Fringe Benefits;
- Travel;
- Equipment and Supplies;
- Contractual;
- Other; and

- Indirect Costs.

Up to 50% of the HHSC Family Planning Program funds may be disbursed to contractors through a voucher system as expenses are incurred during the contract period. Program income must be expended before categorical funds are requested through the voucher process. Contractors must still submit vouchers monthly even if program income equals or exceeds program expenses, or if the contract reimbursement limit has been met. When program expenses exceed program income, the monthly voucher will result in a payment. Program income includes all fees paid by the individuals and HHSC FPP fee-for-service reimbursements.

To request reimbursement for the categorical contract, the following forms must be submitted by the last business day of the following month in which expenses were incurred or services provided:

- State of Texas Purchase Voucher (HHSC Form B-13);
- Supporting Schedule for HHSC FPP Reimbursement Vouchers (Form B-13X)

The following forms must be submitted within **45 days following the end of the contract term**:

- Final State of Texas Purchase Voucher (HHSC Form B-13)
- Supporting Schedule for HHSC FPP Reimbursement Vouchers (Form B-13X).

Fee-for-Service Reimbursement

The fee-for-service component of the HHSC FPP funding pays for direct medical services on a fee-for-services basis. Up to 100% of HHSC FPP funds may be reimbursed on a fee-for-service basis. Each contracting agency is responsible for determining an individual's eligibility for clinical services. The HHSC FPP reimburses contractors on a fee-for-service basis for services and supplies that have been provided to eligible individuals. HHSC FPP contractors must continue to provide services to established individuals and to submit and appeal claims for individual services even after the contract funding limit has been met.

All contractors are required to submit claims for all HHSC FPP services to TMHP use the 2017 Claim Form. A copy of the [2017 Claim Form](#) is available from the TMHP website. The TMPPM provides detailed instructions of how to complete the form, including required and optional fields.

Effective May 1, 2017, FPP (FPP) providers are able to submit professional claims electronically using a modified CMS-1500 electronic claim form.

HHSC FPP claims or appeals must be filed within certain timeframes:

- Initial claims submission: Submitted within 95 days of the date of service on the claim or date of any third-party insurance explanation of benefit (EOB). If the 95th day falls on a weekend or holiday, the filing deadline is extended until the next business day.
- Appeals: Submitted within 120 days of the date on the R&S Report on which the claim reaches a finalized status. If the 120th day falls on a weekend or holiday, the filing deadline is extended until the next business day. If the claim is denied for late filing due to the initial submission deadline, documentation of timely filing must be submitted along with the claim appeal. Refer to the TMPPM for further information.
- All claims and appeals must be submitted and processed within 60 days after the end of the contract period.
- All claims must continue to be billed and denied claims appealed even after the contract funding limit has been met.

HHSC FPP contractors may contact the TMHP Contact Center from 7:00 a.m. to 7:00 p.m. (CST), Monday through Friday at 800-925-9126 for questions about claims and payment status.

HHSC FPP Reimbursable Codes

HHSC FPP reimbursement is limited to a prescribed set of procedure codes approved by HHSC. For a complete list of valid HHSC FPP procedures, see Appendix A.

HHSC FPP contractors may submit claims for individuals' office visits that reflect different levels of service for new and established individuals. A new individual is defined as one who has not received clinical services at the contractor's clinic(s) during the previous three years. The level of services, which determines the procedure code to be billed for that individual visit, is indicated by a combination of factors such as the complexity of the problem addressed, and the time spent with

the individual by clinic providers. The [American Medical Association \(AMA\)](#) publishes materials related to Current Procedural Terminology (CPT) ® coding that include guidance on office visit codes (Evaluation and Management Services – E/M).

Medroxyprogesterone Acetate Injection

Providers may not bill a lower complexity office visit code (99211/99212) when the primary purpose is for the individual to receive an injection of Medroxyprogesterone acetate (Depo-Provera/DMPA/depo) injection. Rather, contractors should bill the injection fee (96372) with the Depo-Provera contraceptive method (J1050).

Electronic Claims Submission

All HHSC FPP contractors are strongly encouraged to submit claims electronically. TMHP offers specifications for electronic claims formats. These specifications are available from the TMHP Provider Portal and relate the paper claim instruction to the electronic format. Contractors may use their own claims filing system, vendor software, or TexMedConnect (a free Web-based claims submission tool available through the TMHP website) for submission of electronic claims. For more information concerning electronic claims submission, contractors may contact the TMHP Electronic Data Interchange (EDI) Help Desk at 512-514-4150 or 888-863-3638. Additional information may be found on the TMHP website.

HTW Claims Pending Eligibility Determination

To verify an applicant's HTW eligibility:

- Individuals will be issued a Your Texas Benefits card with "HTW" printed in the upper right corner.
- Individuals should show their Your Texas Benefits card at the point of service delivery.
- Even with this, though, providers will need to verify the individual's eligibility. Providers can do this by going to www.YourTexasBenefitsCard.com. Or, providers can continue to call TMHP at 1-800-925-9126 or go to TexMedConnect on the TMHP website and check the member's Medicaid ID number (PCN).

Contractors must hold claims up to 45 calendar days for individuals who have applied to HTW. If an individual's HTW eligibility has not been determined after 45 calendar days, the contractor may bill the service to the HHSC FPP if the individual has a current HHSC FPP eligibility form on file. The contractor can file a HHSC FPP claim before the 45-day waiting period if a copy of the HTW program denial letter is in the individual record before filing the claim.

STERILIZATION BILLING/REPORTING

HHSC FPP contractors can receive reimbursement for vasectomy or tubal ligation/occlusion sterilization procedures as part of their family planning services. The individual may not be billed for any cost above the reimbursement rates. Individual co-pays for sterilizations must follow the contractor's established co-pay policy and may not exceed the allowable amount.

Contractors shall expend no more than 15% of their combined HHSC fee-for-service and HHSC categorical contract amounts on female sterilizations. An exemption may be granted to this policy on a case-by-case basis. Contact famplan@hhsc.state.tx.us for more information.

Allowable sterilization codes and descriptions are presented in Appendix A.

Conditions for Sterilization Procedures

Individuals receiving a vasectomy or tubal ligation/occlusion sterilization procedure must:

- be twenty-one years of age or older;
- be mentally competent; individuals are presumed to be mentally competent unless adjudicated incompetent for the purpose of sterilization;
- not be institutionalized in a correctional facility, mental hospital, or other rehabilitative facility;
- not give consent in labor or childbirth; and
- not give consent if under the influence of alcohol or drugs.

Waiting Period

- FPP contractors may provide sterilization services to their individuals after a waiting period of 30 days.
- Sterilization may be performed within 30 days but more than 72 hours after the date of the individual's signature on this consent form in the following two instances:
 - Premature delivery. The individual's expected delivery date must be completed on the sterilization consent form; or
 - Emergency abdominal surgery. The individual's circumstances must be described on the sterilization consent form.

The consent for sterilization is valid for 180 days from the date of the individual's signature.

Sterilization Consent Form

The TMPPM provides both an English and Spanish version of the Sterilization Consent Form to be used by HHSC FPP contractors. The form may be copied for use and contractors are encouraged to frequently re-copy the original form to ensure legible copies and to expedite consent validation. The TMPPM also includes detailed instructions for the completion of the Sterilization Consent Form. It is important that contractors use the most recent Sterilization Consent Form available. Additionally, it is the contractor's responsibility to ensure that the form is complete and accurate prior to submission to TMHP. For more information regarding the Sterilization Consent Form and Instructions please see Section II, Chapter 2 in this manual.

Sterilization Complications

Contractors may request reimbursement for costs associated with patient complications related to sterilization procedures. Contractors may be reimbursed for approved charges up to \$1,000 per occurrence. To request reimbursement, contractors should provide the HHSC FPP with the following information:

- A copy of the R&S report showing that a sterilization procedure was performed on the individual in question;
- A narrative summary detailing the procedure performed and any related complications;
- All surgical and progress notes for the individual related to the complications of the sterilization procedure;
- The initial operative report for the sterilization surgery; and
- A completed paper 2017 Claim Form detailing the procedures for which the contractor is seeking reimbursement (list all procedures related to the complication even if they are not typically reimbursable under the HHSC FPP).

IUD and CONTRACEPTIVE IMPLANT COMPLICATIONS

Contractors may request reimbursement for costs associated with patient complications related to IUD or contraceptive implant insertions or removals. Contractors may be reimbursed for approved charges up to \$1,000 per occurrence. To request reimbursement contractors should provide the HHSC FPP with the following information:

- A copy of the R&S report showing that an IUD or contraceptive implant insertion or removal procedure was performed on the individual in question;
- A narrative summary detailing the procedure performed and any related complications;
- All surgical and progress notes for the individual related to the complication of the IUD or contraceptive implant insertion or removal procedure; and
- A completed paper 2017 Claim Form detailing the procedures for which the contractor is seeking reimbursement (list all procedures related to the complication even if they are not typically reimbursable under the HHSC FPP).

RETROACTIVE ELIGIBILITY

Title XIX Retroactive Eligibility

Retroactive eligibility occurs when an individual has applied for Medicaid coverage but has not yet been assigned a Medicaid individual number at the time of service. Individuals who are eligible for Title XIX (Medicaid) medical assistance receive three months prior eligibility to cover any medical expenses incurred during that period.

HHSC FPP Retroactive Eligibility

Any co-pay collected from an individual found to be eligible retroactively for Medicaid must be refunded to the individual. If a claim has been paid and later the individual receives retroactive Title XIX (Medicaid) eligibility, TMHP recoups/adjusts the funds paid from the HHSC FPP and processes the claim as Title XIX. A HHSC FPP accounts receivable (A/R) is then established for the adjusted claim.

Note: Contractors are responsible for paying HHSC back the amount of any HHSC FPP A/R balance that may remain at the end of a state fiscal year.

The contractors' HHSC FPP R&S Report(s) will reflect the retroactive Title XIX adjustment with EOB message "Recoupment is due to Title XIX retro eligibility."

Assistance on reconciling R&S reports may be provided through the TMHP Contact Center from 7:00 a.m. to 7:00 p.m. CST, Monday through Friday at 800-925-9126. A TMHP Provider Relations representative is also available for these specific questions, as a representative can be located by region on the TMHP website.

Performing Provider Number and Retroactive Eligibility

HHSC family planning claims do not require a performing provider number for reimbursement. However, if a Title XIX retroactive eligibility claim does not have a performing provider number in a TPI format, TMHP will deny the services. A common EOB message for this specific denial is *EOB 00118: Service(s) require performing provider name/number for payment*. A request for reconsideration of claim reimbursement may be sent to TMHP through the appeal methods.

Note: The performing provider number requirement applies to all Title XIX submissions.

Claims Submitted with Laboratory Services

If a Title XIX retroactive eligibility claim includes laboratory services and the HHSC FPP contractor is not CLIA certified for the date of service on the claim, TMHP will deny the laboratory services. The Title XIX R&S report will reflect *EOB 00488 message: "Our records indicate that there is not a CLIA number on file for this provider number or the CLIA is not valid for the dates of services on the claim"*.

When this occurs, the laboratory that performed the procedure(s) is responsible for re-filing laboratory charges with TMHP to receive Title XIX reimbursement. For claims past the 95-day filing deadline, the laboratory will be required to follow their Medicaid appeals process. Contractors must make arrangements with their contracted laboratory to recoup any funds paid to the laboratory for lab services for HHSC FPP individuals prior to Title XIX retro eligibility determination.

Patient Co-Pays

Title XIX does not allow providers to collect co-pays. HHSC FPP contractors must refund any co-pay collected if the individual services were billed to Title XIX.

Also see Section II, Chapter 1 for HHSC FPP for co-pay guidelines.

NOTE: Contractors who have expended their awarded funds must continue to serve their existing eligible individuals and submit fee-for-service claims for services provided. It is allowable to obtain other funding to pay for these services as well as continue to charge co-pay per policy. This funding should be recorded as program income for the FPP contract.

DONATIONS

Voluntary donations from individuals are permissible. However, individuals must not be pressured to make donations, and donations must not be a prerequisite to the provision of services or supplies. Donations are considered program income per specification of contract general provisions. All donations must be documented by source, amount, and date they were received by the contractor. Contractors

must have a written policy on the collection of donations. Individual donations collected by the contractor must be utilized to support the delivery of family planning services.

REQUIRED REPORTS

Financial Reporting

VOUCHER AND REPORT SUBMISSION – Categorical

PROGRAM INFORMATION:

Program Name: HHSC FPP

Contract Type: Categorical

Contract Term: July 1 thru August 31

VOUCHER: Voucher

Voucher Name: HHSC Voucher Form 4116 in Excel format.

Submission Date: By the last business day of the month following the month in which expenses were incurred or services provided. Final voucher due within 45 days after end of the contract term.

Submit Copy to:

Name of Area	Original Signature Required		Accepted Method of Submission	# Copies
	Yes	No		
Women's Health & Educational Services Mailbox:		X	Email	1

WHSFinance@hhsc.state.tx.us

Instructions: Attach B-13X to voucher form 4116.

NOTE: Vouchers must be submitted each month even if there are zero expenditures. Vouchers must still be submitted each month for actual expenditures of the program even if the contract limit has been reached.

VOUCHER: Voucher Supporting Document

Report Name: Supporting Schedule for Family Planning Reimbursement Vouchers Form B-13X in Excel format.

Submission Date: By the last business day of the month following the month in which expenses were incurred or services provided. Final B-13X due within 45 days after end of the contract term.

Submit Copy to:

Name of Area	Original Signature Required		Accepted Method of Submission	# Copies
	Yes	No		
Women's Health & Educational Services Mailbox:		X	Email	1
WHSFinance@hhsc.state.tx.us				

Instructions: Attach B-13X to 4116.

FINANCIAL REPORT: Financial Status Quarterly Report

Report Name: Financial Status Report Form 269A

Submission Date: Reports are due as follows: Quarter 1: September – November; Quarter 2: December – February; Quarter 3: March – May; Quarter 4: June – August. Submit 30 days after the end of each quarter. The final quarterly FSR is due 45 days after the end of the contract term. The final quarter report includes all final charges and expenses associated with the program contract. Mark it as "Final".

Submit Copy to:

Name of Area	Original Signature Required		Accepted Method of Submission	# Copies
	Yes	No		

Yes

No

☐

Women's Health & Education Services

X

Email

1

Mailbox:

WHSFinance@hhsc.state.tx.us

Instructions: Form 269A must have an original signature (scanned email or fax accepted).

FINANCIAL REPORT: Fee-for-Service Report

PROGRAM INFORMATION:

Program Name: HHSC FPP

Contract Type: Fee-for-Service (File Furnished Voucher thru TMHP TexMed Connect/Compass 21)

Contract Term: September 1 thru August 31

FEE-FOR-SERVICE CLAIMS SUBMISSION INFORMATION:

2017 Claim Form - File Furnished Voucher thru TMHP TexMed Connect/Compass 21

Claims Filing Deadline: Within 95 days from date of service or date of 3rd party insurance EOB form. Within 45 days after the end of the contract term.

Claims Submission Entity: Texas Medicaid Healthcare Partnership/Compass 21

NOTE: Claims must continue to be submitted to TMHP TexMed Connect/Compass 21 even if the contract limit has been reached.

NOTE: Appeals must be submitted within 120 days of rejection during the contract term.

All appeals must be submitted and finalized within 45 days after the end of the contract term.

Report Name: Financial Reconciliation Report (FRR)

Submission Date: No later than 60 days after the end of the contract term.

Submit Copy to:

Name of Area	Original Signature Required		Accepted Method of Submission	# Copies
	Yes	No		
Women's Health & Education Services	Yes	No		
Mailbox: WHSFinance@hhsc.state.tx.us	X		Email, scan, or fax	1

Instructions: FRR form does require a signature (scanned or fax accepted). FRR only necessary if contractor only has fee for service component without cost reimbursement component.

Financial Status Reports (FSRs) for Categorical Family Planning Contracts

The HHSC FPP operates using the FFS award, categorical award, and anticipated co-payments to be collected as the total budget. All revenue directly generated by or earned as a result of the project (co-payments), along with FFS reimbursement are considered program income on the quarterly FSRs. FPP contractors with categorical funding are required to identify and report receipt and expenditure of co-payments and FFS payments quarterly and annually on the FSR form 269A. See quarters for categorical FSR submission below. Program income (co-payments and FFS payments), must be expended prior to receiving reimbursement for program costs.

The quarterly reports are due by the last business day of the month following the end of each quarter of the contract term. The final FSR, 269A, is due within 45 days after the end of the contract term, unless stipulated differently in the contract attachment following the end of the contract term. HHSC reserves the right to base funding levels, in part, upon the contractor's

proficiency in identifying, billing, collecting, and reporting income, and in utilizing it for the delivery of family planning services.

Quarters for Categorical FSR submission:

Quarter 1: September – November

Quarter 2: December – February

Quarter 3: March – May

Quarter 4: June – August

FPP Categorical Budget Revisions

Contractors are not required to obtain approval from HHSC for cumulative budget transfers up to 10% of their total FPP categorical direct budget, with the exception of the Equipment category. Transfer to or from the Equipment category requires prior approval from HHSC.

Contractors must obtain prior approval from HHSC for cumulative budget transfers that exceed 10% of their total FPP categorical direct budget.

Contractors are required to submit a revised budget to HHSC for review anytime a budget revision is made.

Programmatic Reporting

The FPP Promotion/Outreach Annual Report must be sent to: famplan@hhsc.state.tx.us. The report is due within forty-five (45) days after the end of the contract period (October 15).

REIMBURSABLE CODES

EVALUATION AND MANAGEMENT	
99201	Office Visit. New Individual. Problem focused history/exam. Straightforward decision-making.
99202	Office Visit. New Individual. Expanded problem focused history/exam. Straightforward medical decision-making.
99203	Office Visit. New Individual. Detailed history/exam. Low complexity decision-making.
99204	Office Visit. New Individual. Comprehensive history/exam. Moderate complexity decision-making.
99205	Office Visit. New Individual. Comprehensive history/exam. High complexity decision-making.
99211	Office Visit. Established Individual. Minor problem focus. Straightforward decision-making.
99212	Office Visit. Established Individual. Problem focused history/exam. Straightforward decision-making.
99213	Office Visit. Established Individual. Expanded problem focused history/exam. Low complexity decision-making.
99214	Office Visit. Established Individual. Detailed history/exam. Moderate complexity decision-making.
99215	Office Visit. Established Individual. Comprehensive history/exam. High complexity decision-making.
99241	Office Consultation. New or Established Individual. Problem focused history/exam. Straightforward decision-making.
99242	Office Consultation. New or Established Individual. Expanded problem focused history/exam. Straightforward decision-making.
99243	Office Consultation. New or Established Individual. Detailed history/exam. Low complexity decision-making.
99244	Office Consultation. New or Established Individual. Comprehensive history/exam. Moderate complexity decision-making.

99384	Preventive Visit. New Individual. Age 12 – 17.
99385	Preventive Visit. New Individual. Age 18 – 39.
99386	Preventive Visit. New Individual. Age 40 – 64.
99394	Preventive Visit. Established Individual. Age 12 – 17.
99395	Preventive Visit. Established Individual. Age 18 – 39.
99396	Preventive Visit. Established Individual. Age 40 – 64.
59430	Postpartum visit
RADIOLOGY	
71010	Chest x-ray 1 view frontal
71020	Chest x-ray 2 view frontal and lateral
73060	Radiologic examination x-ray, humerus, minimum of two views
74000	X-ray, abdomen, single a/p view
74010	X-ray, abdomen, a/p and additional views
74740	Hysterosalpingogram
76098	Radiological exam, surgical specimen
76641	Ultrasound, complete examination of breast including axilla, unilateral
76642	Ultrasound, limited examination of the breast including axilla, unilateral
76700	US exam, abdominal, complete
76705	US exam, abdominal, limited
76770	US exam abdominal back wall, comp
76801	OB US < 14 weeks, single fetus
76802	OB US <14 weeks, additional fetus
76805	Ultrasound pregnant uterus, ≥>/= 14 weeks' gestation, single or 1 st gestation

76810	US exam, pregnant uterus, multiple gestation
76811	OB US, detailed, single fetus
76813	OB US, nuchal measure, 1 gestation
76815	Ultrasound of pregnant uterus, limited
76816	Ultrasound of pregnant uterus as follow-up of abnormal previous scan
76817	Transvaginal US, obstetric
76818	Fetal biophysical profile with W/NST
76819	Fetal biophysical profile with/out NST
76820	Umbilical artery echo
59025	Fetal non-stress test
76830	Ultrasound, transvaginal
76856	Ultrasound, pelvic, non-obstetric
76857	Ultrasound, pelvic, non-obstetric, limited or follow-up
76881	Ultrasound, extremity, nonvascular, real-time with image documentation, complete
76882	Ultrasound, extremity, nonvascular, real-time with image documentation, limited, anatomic specific
76942	Echo guide for biopsy
76998	Ultrasound guidance, intraoperative
77051	Computer dx mammogram add-on
77053	Mammary ductogram or galactogram, single duct, global fee
77065	Mammogram, one breast
77066	Mammogram, both breasts
77067	Mammogram, screening, appropriate for male and female

77058	Magnetic resonance imaging, breast, with and/or without contrast, unilateral, global fee
77059	Magnetic resonance imaging, breast, with and/or without contrast, bilateral, global fee
G0202	Screening Mammography digital
G0204	Diagnostic mammography, (producing direct 2-d digital image, bilateral, all views)
G0206	Diagnostic mammography, (producing direct 2-d digital image, unilateral, all views)

MEDICATIONS, IMMUNIZATIONS AND VACCINES

90460	IM admin 1 st /only component
90471	Immunization admin
90472	Immunization admin, any route, each additional vaccine (single or combination)
90632	Hep A vaccine, adult, IM
90633	Hep A vaccine, ped/adol, 2 dose, IM
90636	Hep A/Hep B vaccine, adult, IM
90649	HPV vaccine 4 valent, IM
90650	HPV vaccine 2 valent, IM
90651	HPV vaccine 9-valent, IM
90654	Flu vaccine, split virus, preservative-free, for intradermal use
90656	Flu vaccine no preservative 3 years & >and older
90658	Flu vaccine 3 years and older, IM
90660	Flu vaccine, live, no preservative, trivalent, IM
90670	Pneumococcal vaccine, 13 Val IM
90673	Flu vaccine, no preservative, trivalent, IM

90686	Flu vaccine, no preservative, quadrivalent, 3 years and older
90688	Flu vaccine, quadrivalent, split virus
90707	MMR vaccine, live, SC
90710	MMRV vaccine, live, SC
90714	Td vaccine, no preservative, age 7 and older/>>, IM
90715	Tdap vaccine, age 7 and older/>>, IM
90716	Chicken pox vaccine, IM
90723	Diphtheria, pertussis, tetanus, Hepatitis B, IMPV
90732	Pneumococcal vaccine, SC or IM
90733	Meningococcal vaccine, SC
90734	Meningococcal vaccine, IM
90736	Zoster vaccine, SC
90743	Hep B vaccine, adolescent, 2 dose, IM
90744	Hep B vaccine, birth – 19 years, 3 dose, IM
90746	Hep B vaccine, 20+ years, 3 dose, IM
96372	Non-neoplastic hormonal therapy injection
A9150	Non-Rx drugs
J0558	Penicillin G benzathine/procaine injection
J0561	Penicillin G benzathine injection
J0690	Cefazolin sodium injection
J0696	Ceftriaxone sodium injection
J0702	Betamethasone sodium phosphate & acetate
J1100	Dexamethasone sodium phosphate

J1725	Hydroxyprogesterone caproate injection
J2010	Lincomycin injection
J2790	Rho D immune globulin injection
J3490	Injection Medication for STD or G/U infection
S5000	Oral prescription medication, generic
CONTRACEPTIVE METHOD	
H1010	Instruction, NFP
A4261	Cervical cap
A4266	Diaphragm
A4267	Condom, male, each
A4268	Condom, female, each
A4269	Spermicide (e.g., foam, gel) each, 6 suppositories or film are quantity of 1
S4993	Oral contraceptive pills, one cycle
J7297	Liletta IUD (52mg levonorgestrel-releasing intrauterine contraceptive)
J7298	Mirena IUD (52mg levonorgestrel-releasing intrauterine contraceptive)
Q9984	Kyleena IUD-(19.5 mg levonorgestrel -releasing intrauterine contraceptive)
J7300	Copper intrauterine contraceptive
J7301	Skyla IUD (13.5 mg levonorgestrol intrauterine contraceptive)
J7303	Vaginal ring, each
J7304	Contraceptive patch, each
J7307	Implantable contraceptive capsule
CONTRACEPTIVE METHOD-RELATED SERVICES	
57170	Diaphragm or cervical cap fitting w/ instructions

58300	Insertion of intrauterine device
58301	Removal of intrauterine device
11982	Removal Non-biodegradable drug delivery Implant
11983	Removal with re-insertion, Non-biodegradable drug delivery Implant
58562	Hysteroscopy, surgical; with removal of impacted foreign body
J1050	Medroxyprogesterone acetate for contraceptive use, injection
96372	Injection fee, Medroxyprogesterone acetate
11976	Removal, implantable contraceptive
11981	Non-biodegradable drug delivery implant insertion
COUNSELING & EDUCATION	
90791	Psychiatric diagnostic interview without medical services
90792	Psychiatric diagnostic interview for provider of medical services
97802	Medical nutrition therapy, initial assessment, individual, face to face, each 15 minutes
97803	Medical nutrition therapy, reassessment, individual, face to face, each 15 minutes
97804	Medical nutrition therapy, group (2 or more), each 30 minutes
99078	Group health education
99406	Behavior change, smoking 3-10 minutes
99407	Behavior change, smoking >10 minutes
PATHOLOGY & LABORATORY	
80061	Lipid profile w/ cholesterol
80300	Drug screen, qualitative/multiple
80301	Drug screen, single

81000	Urinalysis, by dipstick or tablet, non-automated, with microscopy
81001	Urinalysis, by dipstick or tablet, automated, with microscopy
81002	Urinalysis, dipstick or tablet, non-automated, without microscopy
81003	Urinalysis, by dipstick or tablet, automated, without microscopy
81005	Urinalysis, qualitative or semiquantitative
81015	Urinalysis, microscopic only
81025	Urine pregnancy test, visual comparison methods
82947	Glucose, blood, except reagent strip
82948	Glucose, blood, reagent strip
83036	Hemoglobin A1c
84443	Thyroid Stimulating Hormone
84702	Chorionic gonadotropin, quantitative (pregnancy test)
84703	Chorionic gonadotropin, qualitative (pregnancy test)
85013	Microhematocrit, spun
85014	Hematocrit
85018	Hemoglobin
85025	CBC with differential, automated
85027	CBC, automated
86318	Immunoassay, infection agent
86580	Tb skin test, intradermal
86592	Syphilis
86689	HTLV/HIV confirmatory test
86695	Herpes simplex, type 1

86696	Herpes simplex, type 2
86701	HIV-1 antibody
86702	HIV-2 antibody
86703	HIV-1 and HIV-2, single assay
86762	Rubella antibody
86803	Hepatitis C antibody
86900	Blood typing, ABO
86901	Blood typing, Rh
87070	Culture, bacterial; any source other than blood or stool; with presumptive identification of isolates
87086	Urine culture, bacterial, quantitative
87088	Urine culture, bacterial, with presumptive identification of isolates
87102	Culture, fungi, with presumptive identification of isolates, source other than blood, skin, hair, or nail
87110	Chlamydia culture
87205	Smear with interpretation, routine stain for bacteria, fungi or cell types
87210	Wet mount for infectious agents (e.g. saline, India ink, KOH preps)
87220	Tissue examination by KOH slide of samples from skin, hair or nails for fungi, ectoparasite ova, mites
87252	Virus isolation, tissue culture inoculation and presumptive identification (herpes)
87389	HIV-1 AG w/ HIV-1 & HIV 2 AB
87480	Candida species, direct probe technique
87490	Chlamydia, direct probe technique
87491	Chlamydia, amplified probe technique
87510	Gardnerella vaginalis, direct probe technique

87535	HIV-1 probe & reverse transcription
87590	Gonorrhea, direct probe technique
87591	Gonorrhea, amplified probe technique
87624	HPV, high-risk types
87625	HPV, types 16 and 18 only
87660	Trichomonas vaginalis, direct probe technique
87797	Infectious agent, NOS, direct probe
87800	Infectious agent, multiple organisms, direct probe technique
87801	Infectious agent, multiple organisms, amplified probe technique
87810	Chlamydia, immunoassay w/ direct optical observation.
87850	Gonorrhea, immunoassay with direct optical observation
88142	Cytopathology, cervical/vaginal, liquid based, automated
88150	Cytopathology, cervical/vaginal, slides, manual
88164	Cytopathology, cervical/vaginal, slides, manual, the Bethesda System
88175	Cytopathology, cervical/vaginal, any reporting system, fluid based, automated screening with manual rescreening or review.
80048	Basic metabolic panel
80053	Comprehensive metabolic panel
85730	Thromboplastin time, partial
88305	Tissue exam by pathologist
88307	Tissue exam by pathologist
93000	Electrocardiogram, complete
88141	Cytopath, cervical or vaginal (C/V), interpret
88143	Cytopath, C/V thin layer, redo

88173	Cytopath evaluation, FNA, report
88174	Cytopath, C/V auto, in fluid
80050	General health panel
80051	Electrolyte panel
80053	Comprehensive metabolic panel
80069	Renal function panel
80074	Acute hepatitis panel
80076	Hepatic function panel
82270	Occult blood, feces
82465	Total cholesterol
82950	Glucose test
83020	Hemoglobin electrophoresis
83021	Hemoglobin chromatography
83036	Glycosylated hemoglobin test
84450	Transferase (AST) SGOT)
84460	Alanine amino (ALT) (SGPT)
84478	Assay of Triglycerides
84479	Assay of thyroid (T3 or T4)
85007	Differential WBC count
85610	Prothrombin time (PT)
85660	RBC sickle cell test
85730	Thromboplastin time, partial (PTT)
86631	Chlamydia trachomatis, immunofluorescent technique

86677	Helicobacter pylori antibody
86704	Hepatitis B core antibody, total
86706	Hepatitis B surface antibody
86780	Treponema pallidum
86885	Coombs test, indirect, qualitative
87270	Chlamydia trachomatis, immunofluorescent technique
87512	Gardnerella vaginalis, quantification
87529	HSV, DNA, amplified probe
87530	HSV, DNA, quantitative
87661	Trichomonas vaginalis, amplified
88155	Cytopath, C/V, index add-on
88160	Cytopath smear, other source
88161	Cytopath smear, other source
88165	Cyopath, bethesda system, w/manual screen/rescreen
88167	Cytopathology, Bethesda system, cervical/vaginal, select
88172	Cytopathology, evaluation of fine needle aspirate
80055	Obstetric panel
80300	Drug screen, single
82105	Alpha-fetoprotein, serum
82677	Estriol (UE3)
82951	Glucose tolerance test (GTT)
84436	T4
84479	Assay of thyroid (T3 or T4)

85384	Fibrinogen
85610	Prothrombin time
86336	Inhibin A
86777	Toxoplasmosis, IgG IFA
86778	Toxoplasmosis, IgM
86850	Blood, antibody screen
86900	Blood group type
86901	Rh type
87081	GBS culture
87184	Susceptibility test
87340	Hepatitis B surface antigen, by enzyme immunoassay
94760	Non-invasive pulse oximetry for oxygen saturation
99000	Specimen handling or conveyance
ANESTHESIA	
00851	Anesthesia for sterilization, lower abdomen
00400	Anesthesia for procedures on the integumentary system, anterior trunk
00940	Anesthesia for vaginal procedures (including biopsy of cervix), NOS
SURGICAL PROCEDURES	
55250	Male sterilization, vasectomy
58340	Catheter for hysteroigraphy
58565	Female sterilization, hysteroscopy with bilateral fallopian tube cannulation and placement of permanent implants to occlude the fallopian tubes
58600	Female sterilization, fallopian tube transection, blocking, or other procedure

58611	Female sterilization, fallopian tube transection performed at time of cesarean delivery
58615	Female sterilization, occlusion of fallopian tubes by device, vaginal approach
58670	Female sterilization, laparoscopy with fulguration of oviducts
58671	Female sterilization, laparoscopy with occlusion of oviducts by device
10022	FNA with image
19000	Drainage of breast lesion
19081	Breast biopsy first lesion, includes stereotactic guidance
19082	Breast biopsy, with placement of localization device and imaging of biopsy specimen, percutaneous, stereotactic guidance, each additional lesion
19083	Breast biopsy, first lesion, US imaging
19084	Breast biopsy, with placement of localization device and imaging of biopsy specimen, percutaneous, US guidance, each additional lesion
19100	Breast biopsy, percutaneous, needle core, not using imaging guidance, one or more lesion
19101	Incisional breast biopsy, one or more lesions
19120	Removal of breast lesion
19125	Excision of abnormal breast tissue, duct, nipple or areolar lesion, single lesion; identified by preoperative placement of radiological marker (physician in facility)
19126	Excision of abnormal breast tissue, duct, nipple or areolar lesion, each additional lesion (physician in facility)
19281	Preoperative placement of breast localization device, percutaneous: mammographic guidance, first Lesion (physician in office)
19282	Preoperative placement of breast localization device, percutaneous: mammographic guidance, each additional lesion (physician in office)
19283	Preoperative placement of breast localization device, percutaneous: stereotactic guidance, first lesion (physician in office)

19284	Preoperative placement of breast localization device, percutaneous: stereotactic guidance, each additional lesion (physician in office)
19285	Preoperative placement of breast localization device, percutaneous: ultrasound guidance, first lesion (physician in office)
19286	Preoperative placement of breast localization device, percutaneous: ultrasound guidance, each additional lesion (physician in office)
56405	I & D of vulva/perineum
56420	Drainage of gland abscess
56501	Destroy, vulva lesions, simple
56515	Destroy vulva lesions, complex
56605	Biopsy of vulva/perineum
56606	Biopsy of vulva/perineum
56820	Exam of vulva w/scope
57023	I & D vaginal hematoma, non-ob
57061	Destroy vaginal lesions, simple
57100	Biopsy of vagina
57421	Exam/biopsy of vagina w/scope
57511	Cryocautery of cervix
58100	Biopsy of uterine lining
CERVICAL CANCER SCREENING SERVICES	
57452	Examination of vagina – colposcopy
57454	Vagina examination & biopsy
57455	Biopsy of cervix w/scope
57456	Endocervical curettage w/scope
57460	Cervix excision

57461	Conization of cervix w/scope, leep
57500	Biopsy of cervix
57505	Endocervical curettage
57520	Conization of cervix, cold knife or laser
57522	Conization of cervix, leep
58110	Biopsy done w/colposcopy add-on
SUPPLIES	
A4253	Blood glucose/reagent strips
A4258	Springload device for lancet
A4259	Lancets per box (100 count)
A4264	Intratubal occlusion device

DEFINITION OF INCOME

HHSC Family Planning Program Definition of Income

Types of Income	Countable	Exempt
Adoption Payments		✓
Cash Gifts and Contributions	✓	
Child Support Payments	✓	
Child's Earned Income		✓
Crime Victim's Compensation		✓
Disability Insurance Benefits	✓	
Dividends, Interest, and Royalties	✓	
Educational Assistance		✓
Energy Assistance		✓
Foster Care Payment		✓
In-kind Income		✓
Job Training		✓
Loans (Non-educational)	✓	
Lump-Sum Payments	✓	✓
Military Pay	✓	
Mineral Rights	✓	
Pensions and Annuities	✓	
Reimbursements	✓	
RSDI /Social Security Payments	✓	

Self-Employment Income	✓	
SSDI	✓	
SSI Payments		✓
TANF		✓
Unemployment Compensation	✓	
Veteran's Administration	✓	✓
Wages and Salaries, Commissions	✓	
Worker's Compensation	✓	

A description of all types of countable income is provided below.

Cash Gifts and Contributions – Count unless they are made by a private, non-profit organization on the basis of need; and total \$300 or less per household in a federal fiscal quarter. The federal fiscal quarters are January - March, April - June, July - September, and October - December. If these contributions exceed \$300 in a quarter, count the excess amount as income in the month received.

Exempt any cash contribution for common household expenses, such as food, rent, utilities, and items for home maintenance, if it is received from a non-certified household member who:

- Lives in the home with the certified household member,
- Shares household expenses with the certified household member, and
- Does not have a landlord/tenant relationship.

Child Support Payments – Count income after deducting \$75 from the total monthly child support payments the household receives.

Disability Insurance Payments/SSDI – Social Security Disability Insurance is a payroll tax-funded, federal insurance program of the Social Security Administration.

Dividends, Interest and Royalties – This income is countable with an exception: Exempt dividends from insurance policies as income. Count royalties, minus any amount deducted for production expenses and severance taxes.

Loans (Non-educational) – Count as income unless there is an understanding that the money will be repaid, and the person can reasonably explain how he/she will repay it.

Lump-Sum Payments – Count as income in the month received if the person receives it or expects to receive it more often than once a year. Exempt lump sums received once a year or less, unless specifically listed as income.

Military Pay – Count military pay and allowances for housing, food, base pay, and flight pay, minus pay withheld to fund education under the G.I. Bill.

Mineral Rights – A payment received from the excavation of minerals such as oil, natural gas, coal, gold, copper, iron, limestone, gypsum, sand, and gravel.

Pensions and Annuities – A pension is any benefit derived from former employment, such as retirement benefits or disability pensions.

Reimbursements – Countable, minus the actual expenses. Exempt a reimbursement for future expenses only if the household plans to use it as intended.

RSDI/Social Security Payments – Count the Retirement, Survivors, and Disability Insurance (RSDI) benefit amount including the deduction for the Medicare premium, minus any amount that is being recouped for a prior RSDI overpayment.

Self-Employment Income – Count total gross earned, minus the allowable costs of producing the self-employment income.

Terminated Employment – Count terminated income in the month received. Use actual income and do not use conversion factors if terminated income is less than the income received in a full month. Income is terminated if it will not be received in the next usual payment cycle.

Unemployment Compensation Payments – Count the gross benefit less any amount being recouped for an Unemployment Insurance Benefit overpayment.

VA Payments – Count the gross Veterans Administration (VA) payment, minus any amount being recouped for a VA overpayment. Exempt VA special needs payments, such as annual clothing allowances or monthly payments for an attendant for disabled veterans.

Wages, Salaries, Tips and Commissions – Count the actual (not taxable) gross amount.

Worker's Compensation – Count the gross payment, minus any amount being recouped for a prior worker's compensation overpayment or paid for attorney's fees. Note: The Texas Workforce Commission (TWC) or a court sets the amount of the attorney's fee to be paid.